CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

EF 23907

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 205 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6 Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD. (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14 Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS:

C P Force Records Management Officer 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G42676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G42676

Print or write the causes of death clearly and legibly. Physicians: please write exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5349 Denmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5349 Denmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank L. Hedrick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna Maydebrook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1867

8. AGE: Years	Months	Days	If less than one day
79	3	0	hr. min.

9. Birthplace Mt. Freedom Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Isaac Hedrick.
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Wm. R Hedrick
(b) Address 5349 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-46 (month) (day) (year)
(c) Cemetery or crematory St Marys Hampden
Location Baltimore Md.

18 (a) Funeral director Lazing Bros.
(b) Address 5085 Park Heights Ave

AUG 6 - 1946 (Date rec'd. Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4, 1946 at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to Aug 4 1946 and that I last saw (him) alive on Aug 3 1946.

Immediate cause of death	Duration
Myocarditis	1 week
Hypertension	
Due to Nephritis	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester J. Mills M. D.
Address 5216 Park Hgts Ave Date signed Aug 5 46

X

G42677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1940

Registered No. G42677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs?
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Hawkins Pt. Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Cadogan, Walter Phillip

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lottie Snyder Cadogan
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1872

8. AGE: Years 73 | Months 8 9 | Days 20 | If less than one day hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business US Quarantine Station Curtis Bay, Md.

FATHER
12. Name Walter Cadogan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Singleton
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) BURIAL (b) Date thereof AUG 8 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location 4300 OLD FREDERICK RD

18 (a) Funeral director JOHN F. DENNY, INC.
Address 715 LIGHT ST

19 (a) AUG 6 1946 Huntington Williams, M.D.

VS 196

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1946 at 3:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1946 to Aug. 5 1946 and that I last saw him alive on Aug. 5 1946.

Immediate cause of death Coronary thrombosis with myocardial infarction. — Duration About 18 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Southworth
James L. Southworth, Surgeon M. D.
Address US Marine Hospital Date signed 8/5/46
Baltimore, 11, Md.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

42678

AB-103451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G42678
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 1649 Abbott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Fowlkes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6- 1907

8. AGE: Years	Months	Days	If less than one day
39	4	29	hrs. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Burel (D
13. Birthplace Va.

MOTHER
14. Maiden Name Polly Hicks (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 8/46 (mo.) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County Md

18 (a) Funeral director Mrs. Cath. A. Elliott & Sons
(b) Address 1129 N Caroline Street

AUG 6 - 1946 (Date rec'd by local registrar) (b) Huntington Wm [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4- 1946 at 11.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3- 1946 to 8-4- 1946 and that I last saw h alive on 8-4- 1946.

Immediate cause of death Cerebro-Vascular Accident. — Duration

Due to Hypertensive C-V Disease. —

Due to —

Other Conditions Quadriplegia. —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto City Hosps Date signed 8-7-46

VS 150

1

42679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 42D

G42679 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 Ensor Street
(c) Hospital or institution: 9 & 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Ensor Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Peter A. Walsh

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma E. Inners
6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1883

8. AGE: Years	Months	Days	If less than one day
63	0	2	####### hr. ####### min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Plumbing & Steam Fitting
11. Industry or business: Own business

FATHER
12. Name: Peter Walsh
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Mary ?
15. Birthplace: Unknown

16 (a) Informant: Mrs. Emma E. Walsh
(b) Address: 1623 Ensor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 7th, 1946 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: 2930 Frederick Avenue, Balto., Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue
(By whom certified) (Address)

AUG 6 - 1946

Huntington Williams M.D.

VS 450

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 1946 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Aug. 3 1946 and that I last saw ... alive on Aug. 3 1946

Immediate cause of death: Carcinoma rt. lung — Duration: 6 mos
Hypertension & CV disease — 6 yrs
Due to: Thrombo-angiitis Obliterans
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: W. H. Strangeway
Address: 428 Nunnery Date signed: 8-4-46

642680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. 642680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3669 Ash St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3669 Ash St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Guy R. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1882

8. AGE: Years	Months	Days	If less than one day
64	3	28	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Robert L. Redman
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Riley
15. Birthplace Md.

16 (a) Informant Mary F. Harding.
(b) Address 3669 Ash St.

17 (a) Burial (b) Date thereof Aug 7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory, Woodlawn.
Location Woodlawn, Md.

18 (a) Funeral director L. Kenworthy & Donovan
(b) Address 3615 Chestnut Ave.

AUG 6 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 August 1946 at 5:30 P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inspection thereon and from the evidence obtained by said inspection find that said deceased came to her death on the day stated above.
(Autopsy or Inquiry) (Autopsy or Inquiry)

Immediate cause of death Carcinoma Rectum — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. F. Ramsay, Jr. M.D.
Medical Examiner.
Date signed 3 August 1946

VS 6

G42681

AB-16090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G42681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 16yrs-3mos-6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara B. Schnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18-1860 ~~obiern~~

8. AGE: Years	Months	Days	If less than one day
87 or 86	6	17	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joshua Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Mary O'Donovan
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Edmondson Ave & Woodlawn Rd

18 (a) Funeral director Sollers Funeral Home
(b) Address 1913 Pennsylvania Ave

19 (a) Filed AUG 6 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION AM

20. DATE OF DEATH August 5- 1946, at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5- 1930 to 8-5 1946, and that I last saw h 87 alive on 8-5- 1946.

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive heart disease

Due to

Other Conditions (1) Generalized arteriosclerosis (2) Pulmonary emphysema (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hosp. Date signed Aug 5, 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

42682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

G42682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A. IRENE DYSART

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1865

8. AGE: Years	Months	Days	If less than one day
80	11	29	hr. min.

9. Birthplace Lancaster, Pa. (Town, county, and state)
10. Usual Occupation School teacher (retired)
11. Industry or business Balto. City

FATHER
12. Name Jefferson Dysart
13. Birthplace Lancaster, Pa.

MOTHER
14. Maiden Name Elizabeth Yost
15. Birthplace Lancaster, Pa.

16 (a) Informant Dr. Bertha Tapman Shamer
(b) Address 3300 W. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/8/46 (month) (day) (year)
(c) Cemetery or crematory Woodward Hill Cem.
Location Lancaster, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 6 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1946, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8, 1944 to Aug. 5 1946 and that I last saw h[illegible] alive on Aug. 5 1946.

Immediate cause of death	Duration
Heart failure	
Due to Chronic Myocarditis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Tapman Shamer
Address 3300 W. North Ave. - Date signed 8/5/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

342683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. # 832 — G42683

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Amelia Handy

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1873

8. AGE: Years 72 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Aletha ? ? ?

15. Birthplace

16 (a) Informant Mrs. Mabel Carter

(b) Address 1104 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Holland

(b) Address 1601 Druid Hill Ave.

AUG 6 - 1946 (Date rec'd by registrar) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2/46 at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1946 to 19 ; and that I last saw h[illegible] alive on 8/2/46 19 .

Immediate cause of death — Duration

Due to Cerebral Hemorrhage

Due to Hypertensive

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Holland

Address 1131 Harlem Ave Date signed 8/4/46

G42684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42684 Registered No. 1318

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 N. Chaple St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Chaple St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	Col.	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - 1874

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace East New Market, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business At Home

FATHER
12. Name William Bonds
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Bonds
15. Birthplace Md.

16 (a) Informant Henry Driver
(b) Address 533 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) 8-6-1946 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 · 3 · 1946 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7 · 6 · 1946 to 8 · 3 1946
and that I last saw him alive on 8 · 3 1946.

Immediate cause of death	Duration
Uremia	7
Due to Chr. nephritis	7
Due to Chr. myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. L. Kay Driver M. D.
Address 1420 E. Chase Date signed 8-6-46

G42685

EN. 103449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G42685
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. ? Address unknown
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ware (Wade)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
41 ?	?	?	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave / Records

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-6-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Wm F Jackson
(b) Address 916 Penna Ave.

19 (a) (b) Huntington Williams, M.D. Registrar
AUG 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4th 1946, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2nd 19 46 to Aug 4th 19 46, and that I last saw h 1m alive on Aug. 4th 19 46

Immediate cause of death — Duration
Pulmonary pneumonia — 2 weeks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Rowell Hall M.D.
Address Baltimore City Hosp's. Date signed 8/6/46

G42686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G42686
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED LEVIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Hair Dresser

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Hospt Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Belair & Coplin Sts.

18 (a) Funeral director Jos. Levi Inc

(b) Address 2100 Eutaw Place

19 (a) [illegible] Huntington [illegible]

AUG 8 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1946, at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1946 to Aug. 6 1946 and that I last saw him alive on Aug. 6 1946.

Immediate cause of death Cardiac failure — Duration

Due to Coronary thrombosis & myocardial infarction

Due to Arteriosclerotic Heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Elliott E. Weckman M. D.

Address Sinai Hosp. Date signed 8/6/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Dr Antignani
3300 Maryland Ave

G42687

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G42687
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Christopher Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Christopher Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Andrew Maggus.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1907

8. AGE: Years 38 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Asst Operator Standard Oil Co.

11. Industry or business

FATHER
12. Name Charles Maggus
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Hoffman
15. Birthplace Md.

16 (a) Informant Mrs. Geo. G. Maggus
(b) Address 2706 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Road

19 (a) AUG 6 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1940 to Aug. 3, 1946 and that I last saw him alive on Aug. 3, 1946

Immediate cause of death
Coronary Thrombosis — Duration 5 yrs. 9mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of

23. Signature Philip Antignani M.D.
Address 2942 E. Fayette St. Date signed 8/6/46

VS 150

X

Huntington Williams Registrar

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42688 BC# D51773 BALTIMORE CITY HEALTH DEPARTMENT X 160a G42688 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE & JOHN STS.
(c) Hospital or institution:
HOSP. FOR WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. HOSP. FOR WOMEN OF MD.
(If rural give location)
(e) Citizen of foreign country? Cattle (Kidding)
If yes, name country

3 (a) FULL NAME JOSEPH KEARNEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1946

8. AGE: Years | Months | Days | If less than one day 3 hr. 51 min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name PATRICK BERNARD KEARNEY
13. Birthplace MONTREAL, CANADA

MOTHER
14. Maiden Name ELIZABETH FRANCIS GANN
15. Birthplace NEW YORK, NEW YORK

16 (a) Informant ELIZABETH C. KEARNEY
(b) Address 219 Oakpine Village, Balto., Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Destroyed

18 (a) Funeral director
(b) Address

19 (a) [illegible] 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1946, at 8 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1946 to July 19 1946, and that I last saw h[illegible] alive on July 19, 1946.

Immediate cause of death Respiratory Failure — Duration

Due to Intracranial injury

Due to Trauma during childbirth

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. M. S. Wolbe M. D.
Address Women's Hosp. Date signed 7/20/46

VS 3

X

G42689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G42689 Registered No.

Td. 102825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Bouldin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~of (wife)~~ Raymond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12th 1917

8. AGE: Years 29 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Hannah
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location Cedar Hill, Md

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 AUG 7 - 1946 (Registrar's stamp) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4th 1946 at 4.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20th 1946 to Aug. 4th 1946, and that I last saw her alive on Aug. 4th 1946

Immediate cause of death: Pulmonary tuberculosis, bilateral, far advanced — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marion E. Bachelder M.D.
Address City Hospitals Date signed 8/6/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G42690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G42690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 Belvedere Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F Beavin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1876

8. AGE: Years 70 | Months | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Cigar Maker

11. Industry or business

FATHER 12. Name Tilden Beavin

13. Birthplace Md

MOTHER 14. Maiden Name Not Known

15. Birthplace " "

16 (a) Informant Miss Alexandria Emerson

(b) Address 4104 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-46 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director George A Farley

(b) Address Sutton Pl & Fayette

AUG 7 - 1946 (a) (b) Registrar

(Date received by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1946 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Aug 5 1946 and that I last saw him alive on Aug 4 1946.

Immediate cause of death Coronary Occlusion — Duration

Due to Hypertension

Due to Senility

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Charles J Mees

Address 5276 Park Heights Ave Date signed Aug 6 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G42691

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5505 Gwynn Oak Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel W. Kauffman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Matilda Kauffman
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) October 2, 1870

8. AGE: Years	Months	Days	If less than one day
75	10	3	hr. min.

9. Birthplace Felton, York Co., Pa.
(Town, county, and state)
10. Usual Occupation Cigar Maker
11. Industry or business

FATHER
12. Name Emanuel Kauffman
13. Birthplace York County, Pa

MOTHER
14. Maiden Name Malinda Diehl
15. Birthplace York County, Pa.

16 (a) Informant Mrs. Matilda Kauffman
(b) Address 5505 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof Aug. 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stony Brook Mennonite Cem.
Location York, Pa.

18 (a) Funeral director E. Millis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) AUG 7 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1946 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1946 to Aug 5 1946 and that I last saw him alive on Aug 5 1946.

Immediate cause of death	Duration
Cardiac Asthma	6 hr
Due to Cardio vascular Renal.	2 yr
Due to Uremia	6 da.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Coar M. D.
Address 1202 St. Paul St. Date signed Aug 7/46

G42692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G42692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, then give town)
(d) Street No. 1928 E Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Krummeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Frances Krummeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Thelma Collins
(b) Address 2012 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore Md

18 (a) Funeral director Leuward A. Covington
(b) Address 21 W. 25th St

AUG 7 - 1946 (Date rec'd by Reg.) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Aug 1946, at 10:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.

Date signed 4 Aug 46

G42693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G42693 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2nd Lemmon Ave Parks Sq
(c) Hospital or institution: The Washington Apts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2nd Lemmon Ave Parks Sq
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James B Robinson

3 (b) If veteran, name war —
3 (c) Social Security Account No. 041-09-8158

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emmabord
6 (c) If alive, give age 1880

7. Birth date of deceased (mo., day, yr.) Nov 24 (1880)

8. AGE: Years 65 (65) | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Office Manager
11. Industry or business Shell Oil Co

12. Name of father Wm E. Robinson
13. Birthplace Va. Virginia

14. Maiden name of mother Sarah Robertson
15. Birthplace Washington D.C. Washington D.C.

16 (a) Informant James Robinson
(b) Address Washington Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Gilbert Sly Inc
(b) Address 1219 N Pont St

19 (a) AUG 7 - 1946 (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 46 to 8/5 1946 and that I last saw h alive on 8/5 1946.

	Duration
Immediate cause of death: Cardio respiratory failure	Hours
Due to: Generalized arteriosclerosis	3yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Augustus C. Gabler M. D.
Address 1125 N Pont Date signed 8/6/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G42694

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 ANDRE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 ANDRE ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** HERMAN W. ESCHENBACH

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 215-01-3175

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	DIVORCED

6 (b) Name of husband or wife BESSIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 19, 1888

8. AGE: Years	Months	Days	If less than one day
58	0	17	hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation BAKER

11. Industry or business OTTERBEIN BAKERY

FATHER
12. Name CHARLES ESCHENBACH
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MRS. EVELYN FLETCHER
(b) Address 1435 ANDRE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 8 1946 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE, MD

18 (a) Funeral director WILLIAM COOK, ENG.
(b) Address 1217 ST. PAUL ST.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, MD Registrar

AUG 7 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1946 to Aug 6 1946 and that I last saw him alive on Aug 3 1946

Immediate cause of death — Duration

Edema of Lungs — 2 days

Due to

Due to

Other Conditions Chronic Pulmonary Phthisis — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Lichtenberg

Address 708 E North Ave Date signed 8/6/46

X

G42695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G42695 Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3847 Quarry Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3847 Quarry Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John S Griffith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Alive

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1858

8. AGE: Years 88 | Months 9 | Days 28 | If less than one day: hr. min.

9. Birthplace Ohio (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John S Griffith
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah Akers
15. Birthplace Unknown

16 (a) Informant John S Griffith
(b) Address 3847 Quarry Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden Baltimore

18 (a) Funeral director Wilson & Son
(b) Address 1219 E Lord St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

AUG 7 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1946, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1946 to Aug 4 1946, and that I last saw him alive on Aug 4 1946.

Immediate cause of death: Cardiac Paralysis — Duration

Due to: Arterio Sclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. V. Clift M.D.
Address 5010 Greenleaf Rd Date signed 8/6/46

X

G42696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G42696 Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lindsay Ct. Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Bowie Louise Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Perley W. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1880

8. AGE: Years	Months	Days	If less than one day
65	11	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lesli Hoods
13. Birthplace Md

MOTHER
14. Maiden Name Hattie A. Calvert
15. Birthplace Md (Charlestown)

16 (a) Informant Husband Perley W. Clark
(b) Address Lindsay Courts Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Signature of registrar) Registrar
AUG 7 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1946 at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1945 to 8/6 1946 and that I last saw h.e.r. alive on 8/6 1946.

Immediate cause of death: Cardiac Failure — Duration
Due to: Carcinomatosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
At autopsy: Carcinomatosis Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature Henry Wirt Hollies, M.D.
Address Date signed 8-6-46

G42697

TH. 101172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1362

G42697 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4650 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lottie Locklear (Gordon)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: Edmund

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12th 192[illegible]

8. AGE: Years 22 Months 3 Days 25 If less than one day hr. min.

9. Birthplace S. C (Town, county, and state)

10. Usual Occupation Domestic work

11. Industry or business

FATHER
12. Name Aaron Gordan
13. Birthplace S. C

MOTHER
14. Maiden Name Queenie Moys
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Reccrds

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 AUG 7 1946 Filed by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5th 19 46 at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9th 19 46 to Aug 5th 19 46 and that I last saw h er alive on Aug 5th 19 46

Immediate cause of death: Pulmonary tuberculosis. bilateral, far advanced — Duration

Due to

Due to

Other Conditions Thrombophlebitis, left iliac vein (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mrs. Mary E. McMillan
Address City Hospitals Date signed 8/6/46

VS 150

38-354
G42698

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G42698
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Mayne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-14

8. AGE: Years 32 Months 4 Days 9 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Eldridge Jones

13. Birthplace Va.

MOTHER 14. Maiden Name Rebecca Bolis

15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Co. Md.

18 (a) Funeral director

(b) Address

19 (a) (Date received by registrar) (b) Registrar

AUG 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1946 at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1946 to Aug. 4 1946 and that I last saw h alive on Aug. 4 1946

Immediate cause of death: PULMONARY INFARCTION, MULTIPLE — Duration: Recent

Due to THROMBOSIS OF UTERINE VEINS — Duration: ?

Due to HYPERTENSIVE CARDIOVASCULAR DIS. with CARDIAC FAILURE — Duration: 10 yrs + 3-4 MO.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Of autopsy: Obstet - Small ground in K

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

M. Signature J. Maxwell Williams M. D.

Address Johns Hopkins Hospital Date signed 8-5-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C42699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

C42699 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6609 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6609 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte A/ Crawford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1856

8. AGE: Years	Months	Days	If less than one day
89	8	5	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Crawford
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Dougherty
15. Birthplace Md.

16 (a) Informant Mrs. Gertrude Peddicord
(b) Address 2900 Ailsa Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8/46. (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Westminster, Md.

18 (a) Funeral director Harry F. Duffy
(b) Address 4101 Edmondson Ave.

19 (a) AUG 7 1946 (Date received by registrar) Westminster, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1946 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946 to Aug 5 1946 and that I last saw her alive on Aug 5 1946

Immediate cause of death — Duration

(a) Bronchopneumonia
Due to Senility
Due to
Other Conditions Chronic myocarditis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. E. Richards M. D.
Address Pikesville Md. Date signed 8-9-46

VS 150

G42700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G42700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D of H
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301- E. 25th St (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ---------

3 (a) FULL NAME Nellie Wooters (Eleanor Wooters)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) ---------- 1872

8. AGE: Years	Months	Days	If less than one day
About 74	E.P.		hr. min.

9. Birthplace Centreville, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business ---------

FATHER
12. Name John Tilghman
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Arringdale
15. Birthplace Maryland

16 (a) Informant Miss Rose Wooters
(b) Address 301 E. 25th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks & Son
(b) Address 805 N. Calvert Street

19 (a) Date rec'd AUG 7 1946 (b) Registrar Huntington Williams

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1946, at 8 35 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture skull - intracranial hemorrhage, multiple fractures

Due to

Other Conditions Lacerations, contusions & bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/5/46 at 12/3 7 35 P. M.
(b) Where did injury occur? Rear porch above address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from porch

23. Signature Howard J. Thomas M.D. Medical Examiner.
Date signed 8/6/46

G42701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G42701 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Moravia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) -2-
(e) Length of stay in Baltimore (yrs., mos., or days) 89 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Moravia Avenue
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Emma Florence Stanley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) ---------1857

8. AGE: Years	Months	Days	If less than one day
89	---	--	-- hr. ---min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name William W. Stanley
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Ann Thompson
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. J. Wm. Wittekindt
(b) Address 3207 Moravia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] (b) Huntington Williams, Registrar
[illegible] 45

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1946 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/12 1946 to 5/12 1946 and that I last saw h[illegible] alive on 5/12 1946.

Immediate cause of death: Cellulitis Left Orbital

Due to

Due to

Other Conditions Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Zach. A. Morgan M. D.
Address 6 E. Read St. Date signed 8/13/46

VS 150

G12702

TN. 102910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G12702 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8116 Marietta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Scarbeth Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11th 1875

8. AGE: Years 71 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Scarbath
13. Birthplace Germany

MOTHER
14. Maiden Name Susan Breast
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Immanuel
Location Grindon Lane

18 (a) Funeral director L. Heemann and Son
(b) Address 32 S. Broadway

19 (a) AUG 7 - 1946 Signature of Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5th 19 46 at 5.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15th 19 46 to Aug 5th 19 46, and that I last saw h im alive on August 5th 19 46.

Immediate cause of death: Pulmonary Embol i — Duration: 30 min.

Due to Cardiovascular disease → Arteriosclerosis — 10 yrs +

Due to Diabetes Mellitus — 15 yrs.

Other Conditions Gangrene Rt. foot

(Include pregnancy within 3 months of death)

Date of operation 7-17-46

Major findings of operation: as above

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. O'Neill M.D.
Address Balto. City Hospitals Date signed 7-6-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G42703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G42703

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 231 Myrtle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Higgs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1897

8. AGE: Years	Months	Days	If less than one day
49	2	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Higgs
13. Birthplace Md

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md

16 (a) Informant Mary Alsup
(b) Address 231 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L Brown Co
(b) Address 108 W Monument St

19 (a) AUG 7 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1946, at 5 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1946 to Aug 4 1946 and that I last saw h[illegible] alive on May 13 1946

Immediate cause of death	Duration
(a) Pulmonary Edema	
Due to (b) Arteriosclerotic	
Hypertensive Cardio.	
(c) Chronic Renal Dis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W F Kavanagh M.D.
Address 601 N Carrollton Ave Date signed 8/6/46

G42704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

Registered No. G42704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4332 Falls Road
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4332 Falls Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Elizabeth Shuman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles L. Shuman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1875

8. AGE: Years 71 | Months 3 | Days — | If less than one day hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F Stricklin
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara E Baumheimer
15. Birthplace Germany (Penna)

16 (a) Informant Charles L. Shuman
(b) Address 4332 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Co, Md.

18 (a) Funeral director Bynes Funeral Home
(b) Address 3631 Falls Road

19 AUG 7 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946, at 5:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1946 to 8/6 1946 and that I last saw h[er] alive on 8/6 1946

Immediate cause of death: cerebral thrm.
Due to arteriosclerosis
Due to
Other Conditions

Duration
18 days
yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place) While at work)
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4202 Clarke Date signed 8/7/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

G42705 Registered No.

Please write the causes of death clearly and legibly. Physicians: please be sure that the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 Maryland Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Maryland Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Nora B. Young

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Carroll L. Young

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 31-1879

8. AGE: Years 67 | Months 2 | Days 5 | If less than one day: hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name George Boltinger
13. Birthplace Md.

MOTHER — 14. Maiden Name Susanna Boltinger
15. Birthplace Md.

16 (a) Informant: Mrs Margaret Bull
(b) Address 2124 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co., Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 8-7-1946 (Signature and title) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Aug 5 1946 and that I last saw her alive on Aug 5 1946.

Immediate cause of death: Congestive Heart Failure — Duration —
Due to: Coronary Thrombosis
Due to:
Other Conditions: Hemiplegia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Gilmour M. D.
Address 4017 Falls Rd. Date signed 8/6/46

VS 150

X

G42706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G42706 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town.)
(d) Street No. 2322 Jefferson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry T. Beasley

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-2752

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara M. Beasley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1900

8. AGE: Years	Months	Days	If less than one day
46	5	22	hr. min.

9. Birthplace Operator Va.
(Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Sparrows Point

FATHER
12. Name Brumfeild Beasley
13. Birthplace Va.

MOTHER
14. Maiden Name Mary S. Grey
15. Birthplace Va.

16 (a) Informant Barbara M. Beasley
(b) Address 2322 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Co,
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date) (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3- 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15- 1946, to 8-3- 1946, and that I last saw h alive on 8-3- 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Angina Pectoris	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Moore M. D.
Address 448 N. Broadway Date signed 8-5-46

X

G42707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G42707 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 S. Linwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Krygier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Joseph Krygier (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1882

8. AGE: Years	Months	Days	If less than one day
63 64	8	10	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Vincent Jagodzenski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Joseph Krygier
(b) Address 625 S. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location Germant Hill Rd

18 (a) Funeral director John J. Duda
(b) Address 2249 Hudson St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 7 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1946, at 8.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1946, to June 1946, and that I last saw h[illegible] alive on June 1946.

Immediate cause of death: Acute Myocardial Failure

Due to: ~~Hypertensive Heart~~ Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 hr. | 2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeGrand M.D.
Address 601 S. Edmondson Ave Date signed 8/6/46

Write the causes of death clearly and legibly.

G42708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1084

G42708 Registered No.

Write the causes of death clearly and legibly. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2042 E. Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2042 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Addie Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1897

8. AGE: Years 49 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business Domestic

FATHER
12. Name Daniel Hicks
13. Birthplace Virginia

MOTHER
14. Maiden Name Pinkie Taylor
15. Birthplace Virginia

16 (a) Informant Walter Brown
(b) Address 2042 E. Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus memorial Park
Location Arbutus Md. Balto. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) [illegible] by me

AUG 7 - 1946

Registrar

VS-150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4- 1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1946, to 8-4 1946, and that I last saw him alive on 8-4 1946.

Immediate cause of death: Lobar Pneumonia — Duration 5 days

Due to Colds & Exposure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature J. N. Lake, M.D.
Address 1327 N. Central Ave. Date signed 8-7-46.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G42709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G42709 Registered No.

Type or use ink. Give the causes of death clearly and legibly. Physicians: please write the exact age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 N Bond st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Bond st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Edward Holcombe

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3471

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	M

6 (b) Name of husband or wife Jessie Holcombe
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July - 20 - 1893

8. AGE: Years	Months	Days	If less than one day
53	-	16	hr. min.

9. Birthplace Keysville Va. (Town, county, and state)
10. Usual Occupation Labour
11. Industry or business

FATHER
12. Name Glen Holcombe
13. Birthplace Keysville, Va.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Jessie Holcombe
(b) Address 929 N. Bond st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary.
Location Baltimore. Md.

18 (a) Funeral director Mrs John Bailey
(b) Address 1421 E. Jefferson st.

19 (a) Received by registrar (b) Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August - 5 1946 at 5.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19th 1946 to Aug. 5th 1946, and that I last saw he alive on Aug 5th 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Lafond
Address 822 N. Bond St Date signed 8/9/46

× Laborer

G42710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G42710 Registered No.

Write the causes of death clearly and legibly. Physician: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 547. Orchard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 547. Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Flemming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
58 yrs.	—	-	hr. min.

9. Birthplace Tenn. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Lossie Mae Lindsay
(b) Address 545 Orchard St.

17 (a) Burial (b) Date thereof 8/9/46
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West pnt. Balto Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927. N. mount St.

19 (a) (b) AUG 7 1946
Registrar

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946, at 4A M

21. I certify that death occurred on the date above stated, that I attended deceased from May 5 1946 to 8/6 1946 and that I last saw h[illegible] alive on 8/5 1946

Immediate cause of death

	Duration
Hypertensive Cardio Renal-Vascular	3
Due to	3
Due to	3 yrs
Other Conditions	3 Days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature B. N. Hatcher M. D.
Address 1115 Pine Date signed

G42711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G42711

131a

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes + Clarkeland
(c) Hospital or institution: West Baltimore Gen'l Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) Abt 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) In Md. 27 yrs ~~About 7 Days~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. No. 13 - S. Third Avenue
(If rural give location)
(e) Citizen of foreign country? ~ (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Kaiser

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William F. Kaiser
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1895

8. AGE: Years	Months	Days	If less than one day
51	7	3	hr. ~ min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ~

FATHER
12. Name ? Bramon
13. Birthplace Georgia

MOTHER
14. Maiden Name ? ?
15. Birthplace Georgia

16 (a) Informant William F. Kaiser (Husband)
(b) Address No. 13 - S. 3rd Ave. Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Q.A. Co. Md.

18 (a) Funeral director A. Edward Evans
(b) Address 1400 S. Charles St. Balto. 30, Md.

AUG 7 - 1946 Huntington Williams Md.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 August 1946 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 July 1946 to 6 Aug 1946 and that I last saw h[illegible] alive on 6 Aug 1946

Immediate cause of death: Coronary Thrombosis

	Duration
Due to Intra Cranial Hem.	
Due to Cerebral Sclerosis	
Other Conditions Arteriosclerotic Heart Dis. Hypertension Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester G. Hall M. D.
Address West Balto. Gen'l Hosp. Date signed 8/6/46

G42712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1062

G42712 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3135 Chesterfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3135 Chesterfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN DENNING SENNOTT

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-09-4843

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clara F. Sennott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1884

8. AGE: Years 62 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Crown Cork & Seal

FATHER 12. Name John H. Sennott
13. Birthplace Richmond, Va.

MOTHER 14. Maiden Name Sallie Massey
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Catherine Sennott
(b) Address 3135 Chesterfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) Huntington Williams M.D. Registrar

AUG 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at 8.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1941 to August 6 1946, and that I last saw h. alive on July 31 of the.

Immediate cause of death
Cardiac Insufficiency.
Due to Gen. Arteriosclerosis.
Due to Cer. Thrombosis
Other Conditions Bronchitis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
a
b
c
d

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence L. Gunn M.D.
Address 1761 E. Mt. St. Date signed 8/6/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G42713 Registered No.

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2409 E. Eager Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 E. Eager St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Rosenberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Louis Rosenberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/1882

8. AGE: Years	Months	Days	If less than one day
63 yrs.	8	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Vomastek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Benes
15. Birthplace Czechoslovakia

16 (a) Informant Louis Rosenberger - husband
(b) Address 2409 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 AUG 7 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1946 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3, 1946 to Aug. 6 1946 and that I last saw her alive on Aug. 6 1946

Immediate cause of death	Duration
Metastatic Carcinoma of Lungs	Jan. 1946
Due to Scirrhus Carcinoma of Right Breast.	Mar. 1945
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Lewis, M.D.
Address 160 N. Broadway Date signed 8/6/46

G42714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 197

G42714 Registered No.

Please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3031 Frisby Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Frisby St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Kreiner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ George Kreiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1863

8. AGE: Years	Months	Days	If less than one day
83 yrs.	3	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Ats
13. Birthplace Unknown

MOTHER
14. Maiden Name Anna Schmidt
15. Birthplace Germany

16 (a) Informant Elizabeth A. Linder - dgt.
(b) Address 3031 Frisby Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd, Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) AUG 7 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1946, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1946 to Aug 5 1946 and that I last saw h[illegible] alive on 8-5 1946.

Immediate cause of death

	Duration
Hypertensive arteriosclerosis	
Due to Senile — —	
Due to	
Other Conditions Heart Bundle-Block C-	5 Days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maryland Hospital
Address 700 Belair Rd Date signed 8-7-46

X

G42715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G42715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Tester, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1946

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min.

9. Birthplace Bristol, Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John A. Tester
13. Birthplace Va.

MOTHER
14. Maiden Name Della Otey
15. Birthplace Va.

16 (a) Informant John A. Tester
(b) Address 2016 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John A. Middelton & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Signature of registrar) (b) Huntington Williams M.D. Registrar

AUG 7 1946

V.S. 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1946, at 7:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions after respiratory infection

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mueller M.D. Medical Examiner.
Date signed 8-6-46

C42716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C42716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 E. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benedict P Pfeifer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6 - 1890

8. AGE: Years	Months	Days	If less than one day
55	11	1	hr. min.

9. Birthplace Baltimore Md. (City, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Conrad P Pfeifer
13. Birthplace

MOTHER
14. Maiden Name Caroline Doehne
15. Birthplace

16 (a) Informant Mr. August J. Pfeifer
(b) Address 1617 E. 29th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Keck
(b) Address 5305 Harford Rd.

AUG 7 - 1946 (Date rec'd by registrar) Washington Williams, M.D. (Registrar)

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1946, at 855 A.M.

21. I certify that I took charge of the remains described above, held an inquest & Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Horace J. Mendelsohn, M.D. Medical Examiner.
Date signed 8/7/46

G42717

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1184

G42717 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Mount Moore Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Weatley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife: Bethena Weatley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1918

8. AGE: Years	Months	Days	If less than one day
28	1	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Waiter
11. Industry or business Railroad

FATHER
12. Name Raymond Wheatley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lelia Johnson
15. Birthplace Balto. Md.

16 (a) Informant Lelia Wheatley
(b) Address 522 Montmore Court

17 (a) Burial (b) Date thereof Aug 8 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) 7 1946 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 August 1946 at 11 05 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Terminal broncho-pneumonia

Due to Gunshot wound of left chest involving the Dorsal Cord

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 29 March 1946 M.
(b) Where did injury occur? Chicago, Ill.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Shot self cleaning his gun

23. Signature William A. Helpbold M.D.
Medical Examiner.
Date signed 5 Aug 46

G42718 G42718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46a

Registered No.

Please answer all questions as fully as possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 E. Monument st
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Belgrade Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rachael Solomon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Late Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Poland
(Town, county and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Louis Lester
13. Birthplace Poland

MOTHER
14. Maiden Name Amelia —
15. Birthplace Poland

16 (a) Informant Mrs Sarah Sachs
(b) Address 6 N. Belgrade Rd Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8/46 (month) (day) (year)
(c) Cemetery or crematory Shaarei Zion
Location Hamilton ave Randale

18 (a) Funeral director Sol Levinson Bros
(b) Address 124-26 W. North ave

19 (a) Date received 1946 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1946 to 8/6 1946 and that I last saw her alive on Aug 6 1946

Immediate cause of death Bronchopneumonia — Duration 3 Days

Due to

Due to

Other Conditions Esophageal Carcinoma, Myocardial Failure
(Include pregnancy within 3 months of death)

Date of operation 7/25/46

Major findings of operation: Inoperable

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Perelman M. D.
Address Sinai Hospital Date signed 8/6/46

VS 150

G42719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G42719

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 McKean ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Dalton ave — (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 McKean ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle Colton Nicholas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Stanley Nicholas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1908

8. AGE: Years 38 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Chester town Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henry Colton

13. Birthplace Chestertown Md

MOTHER 14. Maiden Name Harriett Butler

15. Birthplace Chestertown Md

16 (a) Informant Martin Colton

(b) Address 1127 McKean ave

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Aug 8, 1946 (month) (day) (year)

(c) Cemetery or crematory Fairlee Location Queen Anne Co Md

18 (a) Funeral director Mrs Kate R Williams

(b) Address 322 N Schroeder St

19 (a) (b) Huntington Williams, M.D.

AUG 8 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to Aug 6 1946 and that I last saw h alive on Aug 5 1946

Immediate cause of death Carcinoma of Uterus — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Trauerlein M. D.

Address 1122 Eutaw Pl Date signed 8/7/46

X

G42720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G42720

Registered No.

Aug 5 1946 8 05 P

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 N. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 N. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Fletcher Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1905

8. AGE: Years 43 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Public schools

FATHER
12. Name John Fletcher
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Hattie Fauntleroy
15. Birthplace Balto. Md.

16 (a) Informant George Austin
(b) Address 1431 N. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Strickland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Washington Millard, Md.

AUG 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1946 to 8/5 1946 and that I last saw h[illegible] alive on 8/3 1946.

Immediate cause of death: Hypertensive Cardio Renal Vascular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration: 5 Mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Hateley

Address 1 W K Park Date signed 8/9/46

42721 TN. 102634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 136a

G42721 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

26-10

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 264 S. Bouldin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley Stefanski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
? 76			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Stefanski
13. Birthplace Germany

MOTHER
14. Maiden Name Antoniette
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cemetery
Location Dundalk Ave
18 (a) Funeral director John F. Dyda
(b) Address 2269 Hudson St
AUG 8 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7th 1946 at 9.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5th 1946 to Aug. 7th 1946 and that I last saw h Im alive on Aug. 7th 1946

Immediate cause of death: Pulmonary Embali — Duration: 30 min
Due to Phlebothrombosis — 2 wks ?
Due to
Other Conditions Urethral stricture of traumatic old — 10 yrs
(Include pregnancy within 3 months of death)
Date of operation 7-18-46
Major findings of operation: urethral Stricture
of autopsy: Pulm. Embali

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J Orall
Address Balto. City Hosp Date signed 8-7-46 (M. D.)

X

VS 150

G42722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G42722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 W. Baltimore St
(c) Hospital or institution: Bon Secours Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTO, 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 N. Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. EDNELL LANGRALL (EDNELL MUIR LANGRALL)

3 (b) If veteran, name war: no —
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: MR HERBERT L. LANGRALL
6 (c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): 8/13/97
8. AGE: Years 48 | Months 11 | Days 24 | If less than one day: hr. min.
9. Birthplace: MD, Sommersett County (town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: William Lambert Muir
13. Birthplace: Sommersett Co., Md.

MOTHER
14. Maiden Name: Margaret Adeline Bozman
15. Birthplace: Sommersett Co., Md.

16 (a) Informant: Herbert L. Langrall
(b) Address: 4210 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 Aug 8 - 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1946, at 4:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 7-22 1946 to 8-6 1946 and that I last saw her alive on 8-6 1946.

Immediate cause of death: Respiratory & Circulatory Failure — Duration

Due to: Widespread Carcinomatosis from CA of Cervix

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: S. Solomons M.D.
Address: Bon Secours Hosp. Date signed: 8-6-46

Correct age if uncertain. Important. Physicians: please write the cause of death clearly and legibly.

G42723 BALTIMORE CITY HEALTH DEPARTMENT G42723

CERTIFICATE OF DEATH 46E

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write if the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden St.
(c) Hospital or institution: Maryland General Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifelong

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 327 Lyndhurst ST #29 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Howard T. Fastie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma V. Fastie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1878.

8. AGE: Years	Months	Days	If less than one day
67	9	2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Washington T. Fastie
13. Birthplace Md.

MOTHER
14. Maiden Name Emma J. Morgan
15. Birthplace Md.

16 (a) Informant Emma V. Fastie
(b) Address 327 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 10/46 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Mitchell
(b) Address 4101 Edmondson Ave.

AUG 8 - 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Aug. 1946, at 5:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 July 1946, to 7 Aug 1946 and that I last saw him alive on 6 Aug 1946.

Immediate cause of death	Duration
Ulcer duodenum	
Due to Carcinoma of sigmoid Colon, with much metastasis.	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 31 July 1946, & Aug 1946.
Major findings of operation: Carcinoma of sigmoid colon. Colostomy done.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Madison T. Morgan M.D.
Address Maryland General Hospital Date signed 7 Aug 1946

12724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

G42724
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George H Sanborn

3 (b) If veteran, name war —

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/14/1893

8. AGE: Years	Months	Days	If less than one day
53	6	22	hr. min.

9. Birthplace Md (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name W. H. Sanborn,

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Ambrose

15. Birthplace Md

16 (a) Informant Susie Sanborn

(b) Address 1330 N. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Geo. B. Kelson

(b) Address 1363 Pennsylvania Ave

19 Aug 8 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1946, at 10 22 A.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Loo death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy + dilatation + coronary sclerosis of heart; acute nephritis, acute congestion, edema + chron emphysema of lungs, generalized arteriosclerosis, chr. nephritis, laceration of scalp

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.

Date signed 8/7/46

VS 191

42725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √49a

G42725 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette - John St.
(c) Hospital or institution:
Hospital for Women of Maryland ||
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nan Von Mitzel

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Max Von Mitzel
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) April 18, 1872

8. AGE: Years	Months	Days	If less than one day
64	3	21	20 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael J. Redding
13. Birthplace Ireland

MOTHER
14. Maiden Name Ella Flaherty
15. Birthplace New York, N.Y.

16 (a) Informant Nan Von Mitzel
(b) Address

17 (a) *Cremation (b) Date thereof 8/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.
18 (a) Funeral director Wilson Conkling Co.
(b) Address 1219 N. Charles St.
19 (a) 8-9-1946 (b) Registrar
(Date received by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1946, to Aug. 8 1946, and that I last saw her alive on Aug. 8 1946.

Immediate cause of death Carcinomatosis — Duration 6 weeks
Due to Adenocarcinoma of ovary — Duration ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Dykema M.D.
Address W. Preston & Bond Sts. Date signed 8-9-46

MARY DYKEMA, M.D.

42726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G42726

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Hillman St
(c) Hospital or institution: Sinai Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Hillman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. Parish

3 (b) If veteran, name war: No | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widow

6 (b) Name of husband or wife: John C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1878

8. AGE: Years	Months	Days	If less than one day
67	8	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name Richard Loughlin
	13. Birthplace Baltimore Md
MOTHER	14. Maiden Name Annie Ball
	15. Birthplace Baltimore Md

16 (a) Informant John C. Parish
(b) Address 1209 Drummond Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore
18 (a) Funeral director Wilson & Son
(b) Address 1214 N. Gilmor St
Date rec'd by Registrar AUG 8 - 1946 Registrar Washington Heights

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1946, to 8-8 1946, and that I last saw her alive on 19

Immediate cause of death Cardiac Failure — Duration 2 days

Due to Coronary insufficiency

Due to Arteriosclerotic heart disease

Other Conditions Carcinoma Sigmoid Colon; Lobar Pneumonia

(Include pregnancy within 3 months of death)

Date of operation 7-14-46; 8-6-46

Major findings of operation: Carcinoma of sigmoid Colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Royal L Brunn M. D.
Address Sinai Hospital Date signed 8-8-46

VS 150

G42727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G42727
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd. & Calvert
(b) Street address Buxton Road
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co.
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. Ruxton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Carroll Naylor Hinton.
3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.
4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 8 1893
8. AGE: Years 53 | Months 06 | Days 30 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Edward Hinton
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Storms
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret Johnson
(b) Address Ruxton Road
17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Catonsville Md.
18 (a) Funeral director Gilbert Bros.
(b) Address 1211 N. Eutaw St.
Aug 8 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 1946, at 9:25 M
21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1946 to Aug 7 1946, and that I last saw h/a alive on Aug. 7 1946.

Immediate cause of death: Cerebro-Vascular Accident
Due to: Hypertensive Cardio-Vascular
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul B. Tomes, M.D.
Address 33rd & Calvert Sts Date signed 8/7/46

VS 150

G42728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TM. 103284 — 569 — Registered No. G42728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals — 12 - H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 E. 24th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Pilker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11th 1891

8. AGE: Years	Months	Days	If less than one day
55	0	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William Pilker
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Fuller
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial [illegible] (b) Date thereof 8/9/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]
(Name and location)

AUG 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6th 1946 at 7.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29th 1946 to Aug 6 1946, and that I last saw h im alive on Aug. 6 th 1946

Immediate cause of death: Multilocular cyst of the right temporal lobe — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Rawle Hoffman M. D.
Address Baltimore City Hosp Date signed 7 Aug 46

VS 150

Write the causes of death clearly and legibly. Physicians: please write [illegible] is especially important.

2729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G42729
Registered No.

Write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 E Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 E Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Whitney

3 (b) If veteran, name war: NS
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Sing 6

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1863

8. AGE: Years 83 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name James Whitney
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Reynolds
15. Birthplace Ireland

16 (a) Informant Mrs Anna Warren
(b) Address 2115 E Preston St.

17. Burial (Burial, cremation, or removal) (b) Date thereof 8/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cath
Location Baltimore Md

18 (a) Funeral director William J Lee
(b) Address 1210 E Fort Ave

19 Aug 8 - 1946 Signature by William J Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1946 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1946 to Aug 7 1946 and that I last saw h[illegible] alive on Aug 7 1946

[illegible] cause of death

Due to Hypertensive Cardiac

Due to Vascular Lesion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Unk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 1000 N Mad Ave Date signed Aug 9 1946

VS 150

42730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. 642730

Please write the causes of death clearly and legibly. Physicians: please write legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Late Yetta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877 1869

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Simon Becker
13. Birthplace Russia

MOTHER
14. Maiden Name Unknow
15. Birthplace Russia

16 (a) Informant Mrs. Ben Flinkman
(b) Address 1508 N. Pulaski

17 (a) Burial (b) Date thereof Aug 9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel Cemt
Location O'donnells St.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North Ave

AUG 8 - 1946 Washington, D. C.
Date received by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1946 at 8.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 8/7 1946, and that I last saw h alive on 8/7 19 46.

Immediate cause of death Coronary occlusion Duration 12 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 2904 Reisterstown Rd Date signed 8/8/46

G42731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G42731 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cloverdale Rd. & Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-1
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE MEYER.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Isidor Meyer.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1885.

8. AGE: Years	Months	Days	If less than one day
60	8	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Adolph Leeser,
13. Birthplace Germany.

MOTHER
14. Maiden Name Fredericka DeBeer,
15. Birthplace Germany.

16 (a) Informant Mr. Isidor Meyer,
(b) Address Temple Garden Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Harris & Sons
(b) Address 1902 Eutaw Place.

19 AUG 8 - 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7th. 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945 to Aug 7th 1946.
and that I last saw [illegible] alive on Aug 7th 1946.

Immediate cause of death

Due to Arteriosclerotic Heart Disease

Due to Chronic Nephritis

Other Conditions

Duration
7 months
10 yrs
4 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Bru. Brueckel M. D.
Address Emersonian Apts. Date signed

VS 150

G42732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 102

G42732 Registered No.

Please write the causes of death clearly and legibly. Physicians: please be sure that the information is correct as it is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Weyworth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Freida Portney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1929

8. AGE: Years 17 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation School
11. Industry or business

FATHER
12. Name Joe
13. Birthplace Russia

MOTHER
14. Maiden Name Ethel Schwartz
15. Birthplace Baltimore Md

16 (a) Informant Joe Portney
(b) Address 2813 Weyworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-46 (month) (day) (year)
(c) Cemetery or crematory
Location Sefrgio Mount Carmel

18 (a) Funeral director Jack Levey Inc
(b) Address 1659 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington W Registrar

AUG 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946 to Aug 8 1946 and that I last saw h e alive on Aug 8 1946

Immediate cause of death
Operative death due to the 2nd part of a thoraco-lumbar sympathectomy
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Aug 8 at 8:40 AM
(c) Where did injury occur? Baltimore Baltimore Maryland
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? No
(Specify type of place)
(e) Means of injury Sudden death while on operating table

23. Signature Alan D Mackt M. D.
Address Sinai Hospital Date signed Aug 9 1946

Howard J. Mackenzie, M. D.

G42733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193E.

G42733 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 433 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John William Elkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Sedella Elkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1918

8. AGE: Years 28 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace Mineral Co. W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Henry Elkins
13. Birthplace W. Va.

MOTHER 14. Maiden Name Cella Fikens
15. Birthplace W. Va.

16 (a) Informant Father
(b) Address Route 4 Keyser

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/46 (month) (day) (year)
(c) Cemetery or crematory Keyser, W. Va.
Location Queens Ave Cem.

18 (a) Funeral director A. R. Slade
(b) Address 4407 York R. Balto Md.

AUG 8 - 1946 (Date rec'd by registrar) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8- 19 46 at 10 A.M

21. I certify that I took charge of the remains described above, held an Autopsy **thereon and from the evidence obtained by said** Autopsy, Inspection or Inquiry, **find that said deceased came to** his **death on the day stated above, and death in my opinion resulted from: natural causes** ☑ **accident** ☐, **suicide** ☐, **homicide** ☐, **undetermined** ☐ **and that the causes of death were:**

IMMEDIATE CAUSE OF DEATH
Acute Congestive cardiac failure
Acute pulmonary congestion +
Due to edema

Other Conditions Congestion of all other viscera.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ **or contributing** ☐ **cause of death, fill in the following:**
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mancini Medical Examiner M.D.
Date signed 8-8-46

VS 151

42734

AB-103571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 042734

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr-40min
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6533 St. Helens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Shiflett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 32?

8. AGE: Years	Months	Days	If less than one day
32?	?	?	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Shiflett
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Conley
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 8/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Earlysville, Va.

18 (a) Funeral director Wm. J. Lickey & Son
(b) Address North & Penn Aves.

19 AUG 9 - 1946 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8- 1946, 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1946 to 8-8 1946 and that I last saw h 1m alive on 8-8- 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Intravenous Hemorrhage	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham M.D.
Address Baltimore, Md. Date signed Aug 7/46

VS 150

12735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1108

Registered No. G42735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore city Jail 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 - N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Gallagher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 13 1899

8. AGE: Years	Months	Days	If less than one day
46	9	25	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernard Gallagher
13. Birthplace Brooklyn, N.Y.

MOTHER
14. Maiden Name Elizabeth C. Kinkaid
15. Birthplace Richmond, Va

16 (a) Informant Mr. Paul Bliley
(b) Address Richmond, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Richmond, Va.

18 (a) Funeral director Frederick A. Cole
(b) Address 200 N. Lombard St

19 AUG 9 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1946, at 1:0 a. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH
Lobar pneumonia

Due to

Other Conditions Bronchitis + asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Williams M.D.
Medical Examiner.
Date signed 8-8-46

G42736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200 B

G42736 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kent W. Umberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1891

8. AGE: Years 54 | Months 11 | Days 1 3 | If less than one day hr. min.

9. Birthplace With. Co., Va. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Charles W. Umberger

13. Birthplace With Co., Va.

MOTHER 14. Maiden Name Sarah E. Martin

15. Birthplace Montgomery Co., Va.

16 (a) Informant Miss Brooks Umberger

(b) Address Mt. Ulla, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)

(c) Cemetery or crematory Knox Chapel Cem.

Location Monroeville Mt. Ulla, N.C.

18 (a) Funeral director Geo. L. Bayer Jr

(b) Address 1612 Hollins St.

19 (a) AUG 9 - 1946 (Date registered) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7, 1946, at 1 30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Unknown

Due to

Other Conditions Body is in an advanced state of putrefaction.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Williams M.D. Medical Examiner.

Date signed 8-7-46

(Over)

G42737 f

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G42737 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4405 Maine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, widowed, or divorced Widower

6 (b) Name of husband or wife Gertrude Bennett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27-1871

8. AGE: Years 75 | Months 74 | Days 1 | 11 | If less than one day hr. min.

9. Birthplace Eckhart Mines Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Bennett
13. Birthplace Eckhart Mines Md

MOTHER
14. Maiden Name Gertrude Mountz
15. Birthplace Virginia

16 (a) Informant Mr Robert Bennett
(b) Address 4405 Maine Ave

17 (a) Burial, cremation, or removal (b) Date thereof 8/9/46 (month) (day) (year)

(c) Cemetery or crematory
Location Allegheny-Frostburg Md

18 (a) Funeral director Jos J Sterr Hom
(b) Address 3081 Kentucky Ave

AUG 9 - 1946 (Date rec'd by registrar)

(b) Huntington Millington M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at 12-10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to Aug 8 1946 and that I last saw him alive on Aug 8 1946.

Immediate cause of death: (a) Coronary Thrombosis — Duration 1 day

Due to: —

Due to:

Other Conditions: Bronchial Carcinoma — Duration 15 yrs

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl L. Chambers M.D.
Address 4108 Liberty Hts. Date signed 8/7/46

VS 150

X

G42738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G42738 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nehemiah McFadden

3 (b) If veteran, name war

3 (c) Social Security Account No. 251-32-0964

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gussie McFadden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years: 35 | Months | Days | If less than one day: hr. min.

9. Birthplace Manning, S.C. (Town, county, and state)

10. Usual Occupation mechanic

11. Industry or business

FATHER 12. Name Henry McFadden

13. Birthplace S.C.

MOTHER 14. Maiden Name Fannie Charis

15. Birthplace S.C.

16 (a) Informant Eugene Billups

(b) Address 615 S. Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11-46 (month) (day) (year)

(c) Cemetery or crematory Manning

Location S.C.

18 (a) Funeral director James A Hayes

(b) Address 142 W Fayette St

19 (a) [illegible] (b) Huntington Williams, M.D.

AUG 9 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1946, at 12 50 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock - Multiple fractures
Lacerations, Brush Burns +
Contusions,
Laceration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 8.30 8.50 P.M.

(a) Date of injury 8/4/46 at 8 50 P. M.

(b) Where did injury occur? Road + Monastery Sts

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Fractures + Lacerations - hit + run driver

23. Signature Howard J. Anderson M.D. Medical Examiner.

Date signed 8/5/46

G42739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G42739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Parkway, Penn. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Donald H. Simons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Ruth Simons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1899

8. AGE: Years 47 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Hamlin) (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business B&R Engineering Co.

FATHER
12. Name Charles Simons
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Nancy Williams
15. Birthplace Pennsylvania

16 (a) Informant Union Memorial Hosp.
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

AUG 9 - 1946

(b) Name and address of informant Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 2:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1946 to August 8 1946 and that I last saw him alive on 19

Immediate cause of death	Duration
cerebral emboli	1 day
Due to myocardial infarct	8 days
Due to arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul B. Towne, M.D.
Address Union Memorial Hosp. Date signed 8/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G42740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ~~City~~ or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31st & St. Paul St. Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Allen Price

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Mrs. Grace Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1867

8. AGE: Years	Months	Days	If less than one day
79	3	6	hr. min.

9. Birthplace Manchester, Md.
(Town, county, and state)

10. Usual Occupation Salesman (Retired)

11. Industry or business

FATHER
12. Name John Price
13. Birthplace Manchaster, Md.

MOTHER
14. Maiden Name Lelah Brilhart
15. Birthplace Manchester, Pa.

16 (a) Informant Mr. Charles Bartjes
(b) Address 2900 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

19 AUG 9 - 1946 (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1946, at 6.55 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Undetermined.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-5- at 1 3/4 P. M.?
(b) Where did injury occur? Boat Lake, Druid Hill Park.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found in the lake.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8-8-46

G42741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G42741

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 E Lebase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. McKeever

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-9287

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna MacKeever

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th 1874

8. AGE: Years	Months	Days	If less than one day
72 72	4	-	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business Kriss Dairy

FATHER
12. Name Wm. MacKeever
13. Birthplace Md

MOTHER
14. Maiden Name Adelaide Trewella
15. Birthplace Md

16 (a) Informant Mrs Anna MacKeever
(b) Address 2137 E Lebase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)

(c) Cemetery or crematory Mountlands
Location Taylor Ave

18 (a) Funeral director Leo J. Devoto
(b) Address 1701-03 N. Pattison Park

19 AUG 9 - 1946 Filed by Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 August 1946, at 10:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Heart Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 7 Aug. 1946

VS 151

G42742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 51B

G42742 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto City
(If outside city or town limits write RURAL and give town)
(d) Street No. 2101 W Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James J Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Louise M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23-1883

8. AGE: Years 63 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace New Jersey (State, county, and city)

10. Usual Occupation Radio Tech

11. Industry or business

FATHER 12. Name Albert J Cook
13. Birthplace N.Y.

MOTHER 14. Maiden Name Florence C?
15. Birthplace N.Y.

16 (a) Informant Mary A Shieldsdale
(b) Address 113 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd
18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) Date received AUG 9 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1946 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1946 to AUG. 7 1946, and that I last saw him alive on Aug. 7 1946.

	Duration
Immediate cause of death GENERALIZED CARCINOMATOSIS	4 Mo-
Due to CARCINOMA - PROSTATE	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Kleeman M. D.
Address 3803 Edmondson Date signed 8/9/46

VS 150

G42743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G42743 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Hope St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Hope St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Lenz

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.: Widow

6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1899

8. AGE: Years 47 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name George L Bondell
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Caroline Reese
15. Birthplace Baltimore Md

16 (a) Informant Caroline Bondell
(b) Address 2410 Clark St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 8/11 (month) (day) (year)
(c) Cemetery or crematory Ft Fords
Location Baltimore Md

18 (a) Funeral director Gilbert Coffroe
(b) Address 1217 E Fayette St

19 (a) AUG 9 - 1946 (Date rec'd by registrar) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1946 at 10:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1946 to Aug. 8 1946 and that I last saw h[illegible] alive on Aug. 8 1946.

Immediate cause of death: Diabetic Coma — Duration 4 D.

Due to Diabetes Mellitus — ?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Louis Steuber M.D.
Address 1001 E Fayette St Date signed 8/9/46

VS 150

G42744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G42744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Royal Station (on train) DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 N. Barton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph R. Vinzant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Julia Gibbon Vinzant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1896

8. AGE: Years	Months	Days	If less than one day
49 ~~50~~	11	8	hr. min.

9. Birthplace Three Corners, Fla.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Frank Vinzant
13. Birthplace Fla.

MOTHER
14. Maiden Name Frances Sutton
15. Birthplace Fla.

16 (a) Informant Mrs. Frances Sutton
(b) Address

17 (a) Removal (b) Date thereof 8-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Arlington, Va

18 (a) Funeral director Wm. J. Tuckner & Sons
(b) Address South Pierce Ave Belt Rd

19 (a) AUG 9 - 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1946, at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-9-46

(OVER)

G42745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √61

G42745
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose D. Gold

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Herman Gold
(b) Address 3705 Clarinth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-46 (month) (day) (year)
(c) Cemetery or crematory
Location Rodgers Forge Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Baltimore St

19 (a) Washington Williams, M.D. (Date received by registrar) Registrar

AUG 9 - 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1943 to 8-8 1946 and that I last saw h[illegible] alive on 8-8 1946.

Immediate cause of death: Chr. card. vas. disease
Duration:
Due to Diabetes Mellitus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin
Address Levindale Date signed 8/8/46

G42746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G42746 Registered No.

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G42747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G42747 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Mod. Gen. & Linden
(b) Street address 842 Park Ave.
(c) Hospital or institution: Mod. Gen. Hospital 11-B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1M 7D
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 842 Park Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Mrs Sarah Clara Deck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1863

8. AGE: Years	Months	Days	If less than one day
83	4	1	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Callum
15. Birthplace Ireland

16 (a) Informant Robert N. Shutt
(b) Address 201 Midhurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director H. W. Meares & Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (b) Registrar

Voided AUG 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1946, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1946 to 8/8 1946 and that I last saw h alive on 8/8 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Obstruction of esophagus	
Due to Tumor Unknown	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: No malignancy found

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Mitchell

Address Md. Gen. Hosp. Date signed 8/8/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G42748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G42748 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 326 N. Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rufus Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 33 | Months | Days | If less than one day hr. min.

9. Birthplace Savannah, Ga. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name unknown
13. Birthplace Ga.,

MOTHER
14. Maiden Name Lula ?
15. Birthplace Ga.,

16 (a) Informant Dennis Williams
(b) Address 539 W. Mulberry St

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof 8-9-46 (month) (day) (year)
(c) Cemetery or crematory Lawnmah Cem
Location Savannah Georgia

18 (a) Funeral director Wilson & Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3rd 1946 at 1 26 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun shot of abdomen involving the external iliac vein + intestines

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1 A.M. at 8-3-46 M.
(b) Where did injury occur? Mulberry & Diamond
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Shot during altercation

23. Signature Howard A. Letzeisen M.D. Medical Examiner.
Date signed 8-3-46

VS 151

G42749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

G42749

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Balto. Md. 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 da
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
2 City or town Baltimore
(If outside city or town limits, write RURAL and give County)
(d) Street No. 2501 Jefferson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn A. McPherson (EVELYN A. McPHERSON)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1917

8. AGE: Years	Months	Days	If less than one day
34	5	11/30	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frank V. Truma
13. Birthplace Europe

MOTHER
14. Maiden Name Barbara A. Hulka
15. Birthplace Balto Md

16 (a) Informant Barbara A. Truma
(b) Address 945 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balto
18 (a) Funeral Dir. Joff C. & B. M. Walter
(b) Address Pratt & Stricker Sts
19 (a) 5 Aug 46 (Date rec'd by registrar) (b) Baltimore, Md. Registrar
AUG 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1946, at 3:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 1946, to 8/7 1946 and that I last saw h er alive on 8/7 1946

Immediate cause of death Hepatic insufficiency Bronchopneumonia — Duration

Due to Cancer of Liver

Due to Chronic alcoholism

Other Conditions Icterus, Ascites

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Bricker Singer, M.D.

Address Sinai Hospital Date signed 8/7/46

X

G42750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registration No. G42750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4411 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-2
(e) Length of stay in Baltimore (yrs., mos., or days) VS 4(5)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4411 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas C. Ratcliff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Cora Crum Ratcliff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 - 1877

8. AGE: Years	Months	Days	If less than one day
68	8	29	hr. min.

9. Birthplace Hamilton, Ohio
(Town, county, and state)

10. Usual Occupation Retired Vice-Pres & Treas.
11. Industry or business Standard Gas Equipment Corp

FATHER
12. Name John Ratcliff
13. Birthplace Oxford, Ohio

MOTHER
14. Maiden Name Minerva Connor
15. Birthplace Hamilton Co. Ohio

16 (a) Informant Russell Ratcliff
(b) Address Englewood, California

17 (a) Burial (b) Date thereof Aug. 10, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director E. Willis Lamotte
(b) Address 4510 Liberty Heights Ave.

19 (a) AUG 9 - 1946
(Registrar) (Date received)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1946, at 2.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March - 1945 to Aug - 7 1946 and that I last saw him alive on Aug. 6 1946.

	Duration
Immediate cause of death: (a) Cerebral Hemorrhage	4 wks.
Due to: Hypertension	5 yrs.
Due to: Heart Disease	5 yrs.
Other Conditions: Generalized Sclerosis (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hgts Ave Date signed

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G42751 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-1
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 416 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Ellenberger
3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-03-3084

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mary Ellenberger
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) May 12-1884
8. AGE: Years 62 Months 2 Days 22 If less than one day hr. min.
9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation
11. Industry or business Countryman

FATHER
12. Name Elie Ellenberger
13. Birthplace Penna.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary Ellenberger
(b) Address 416 W. Saratoga St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 10 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Philip Feurig Sons
(b) Address 2511 Orleans St.
19 (a) AUG 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1946 4:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from April 3rd 1945 to Aug 8th 1946 and that I last saw h alive on Aug 7th 1946
Immediate cause of death acute dilatation of heart — Duration 24 hrs
Due to Cardio Vascular — 2
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature N. E. Tawkins M.D.
Address 100 N. Milton Ave Date signed 8/8/46

G42752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 446

G42752 Registered No.

Please write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nellie M. Pontier

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife: Harry G. Pontier
6 (c) If single give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1885

8. AGE: Years	Months	Days	If less than one day
61	6	25	4 hr. min.

9. Birthplace Balto - Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Podsetta
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ella Stevenings
15. Birthplace Balto Md

16 (a) Informant Louis James M Pontier
(b) Address 2905 Walbrook Ave

17 (a) Burial (b) Date thereof Aug. 12. 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington National
Location Va.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave

19 (d) AUG 9 - 1946 Curtis G. Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20 1946 to 8/8 1946 and that I last saw h.e.r alive on 8/8 1946

Immediate cause of death	Duration
respiratory failure	
Due to Hodgkins Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K. Bernard Rollins M. D.
Address St Agnes Hosp Date signed 8/8/46

VS 150

G42753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

Registered No. G42753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Lillian
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Williams, Clarence Eugene

3 (b) If veteran, name war

3 (c) Social Security Account No. 224-14-2389

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1915

8. AGE: Years 31 | Months 5 | Days 19 | If less than one day hr. min. 26

9. Birthplace Lillian, Va. (Town, county, and state)

10. Usual Occupation Deckhand

11. Industry or business Seafarer

FATHER
12. Name Merrick Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/46 (month) (day) (year)
(c) Cemetery or crematory Lillian Va
Location Lillian Va

18 (a) Funeral director Wm. S. Kelson
(b) Address 1303 Pennsylvania Ave Huntington W. Va.

19 (a) AUG 9 - 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 19 46, at 9:05A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1946, to Aug. 8 1946, and that I last saw h im alive on Aug. 8 19 46

Immediate cause of death Uremia — Duration 2 wks.

Due to

Due to

Other Conditions Essential malignant hypertension — Duration 3 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

S. P. Van Ekeren, Medical Director
Address Medical Officer in Charge Signed 8/8/46

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

G42754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G42754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 N. Gold st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Gold st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Wilson

3 (b) If veteran, name war
3 (c) Social Security Account No. 220-01-1783

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	widowed

6 (b) Name of husband or wife Sadie Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name George Wilson
13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Lydia Wilson
15. Birthplace Baltimore, Maryland

16 (a) Informant Mabel Smith (daughter)
(b) Address 937 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Maryland.

18 (a) Funeral director Miss Sola Bailey
(b) Address 1421 E. Pratt St. Baltimore, Md.

19 AUG 9 - 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1946, at 5:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1946 to 8-5 1946 and that I last saw h/ alive on 8-5-1946

Immediate cause of death: Hypertensive Cardio Vascular Disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 5-5-4 Dolphin St. Date signed 8-6-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

42755

TM. 102297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G42755 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sollers Home 504 Burr Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Caldwell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Edmonia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 6 1902

8. AGE: Years	Months	Days	If less than one day
43	8	1	hr. min.

9. Birthplace N.C (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Caldwell
13. Birthplace S.C

MOTHER
14. Maiden Name Maggie
15. Birthplace S.C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 46 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Bur
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomingdale ave
(c) Date rec'd by registrar AUG 9 - 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7th 1946 at 9.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1946 to Aug. 7 1946, and that I last saw him alive on Aug. 7th 1946

Immediate cause of death Pulmonary Infarct. Acute bacterial endocarditis — Duration 1 week

Due to Hypertensive cardiovascular disease. — Duration 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Howell Hoffmann M. D.
Address Baltimore City Hosp Date signed 7 Aug 46

VS 150

42756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42756 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 2 - 1
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Dukes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-1929

8. AGE: Years	Months	Days	If less than one day
16	7	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rigby Dukes
13. Birthplace S.C.

MOTHER 14. Maiden Name Ada Gibson
15. Birthplace S.C.

16 (a) Informant Rigby Dukes
(b) Address 142 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley ave

AUG 9 1946 (Staff registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 | 4 1946, at 8:52 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Multiple fractures
Due to

Other Conditions Brain bruises & Lacerations

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/4/46 at 8:30 P. M.
(b) Where did injury occur? Russell St. near Worcester
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in auto collision

23. Signature Howard A. Clemens M.D. Medical Examiner.
Date signed 8/5/46

G42757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G42757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1423 Jefferson St
(c) Hospital or institution: 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Thomas Ames

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John Ames
13. Birthplace Birdsnest, Va

MOTHER
14. Maiden Name Wesley Anna
15. Birthplace Crisfield, Md.

16 (a) Informant William Ames
(b) Address 1011 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem
Location Baltimore Md

18 (a) Funeral director Cleary & Wilson
(b) Address 1000 Druid Park Ave
(c) Signature of undertaker or agent for Williams, M.D.

AUG 9 - 1946

Registrar

VS 150

8/6 **MEDICAL CERTIFICATION** 9:45 PM

20. DATE OF DEATH Aug 6 1946 at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1946 to 8-6 1946.
and that I last saw h alive on 19

Immediate cause of death	Duration
Hypertension	
Cerebro Vascular	1 yr
Due to disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 553 Dolphin St Date signed 8-8-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

42758 4

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G42758
CERTIFICATE OF DEATH
Registered No. 6

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Essex, 21, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Himmelheber Jr. ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-22-7201

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 10-1928

8. AGE: Years	Months	Days	If less than one day
17	8	28	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Commercial Credit Co.

FATHER
12. Name Fred Himmelheber Sr.
13. Birthplace Balto.

MOTHER
14. Maiden Name Katherine Bowman
15. Birthplace Balto.

16 (a) Informant Mr. Fred Himmelheber Sr.
(b) Address 522 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn.
Location Eastern Ave. Rd.

18 (a) Funeral director John D Connelly
(b) Address 418 Eastern Ave. Essex 21

19 (a) AUG 9 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at 4 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1946 to Aug 8 1946 and that I last saw h[illegible] alive on Aug 8 1946

Immediate cause of death Respiratory failure — Duration

Due to Meningococcus meningitis

Due to Toxemia & possible septicemia

Other Conditions Advised by doctor.

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. E. McCurdy M. D.
Address University Hosp. Date signed 8-8-46

X

42759 (Md)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 42759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Fairway Rd. Eastern Ter. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Glenn Francis Hohl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14-1946

8. AGE: Years | Months: 1 | Days: 14 | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Warren Roop Hohl.

FATHER 13. Birthplace Honeybrook Pa.

MOTHER 14. Maiden Name Mary Helen Diefenderfer

MOTHER 15. Birthplace Dover Delaware.

16 (a) Informant Warren Roop Hohl

(b) Address 6 Fairway Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/46 (month) (day) (year)

(c) Cemetery or crematory Morelands.

Location Taylor Ave.

18 (a) Funeral director John G Connelly.

(b) Address 48 Eastern Ave.

19 (a) 8-9-1946 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9th 1946 at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-pneumonia

Due to

Other Conditions Upper respiratory infection

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Huntington Williams M.D. Medical Examiner.

Date signed 8/9/46

VS 191

42760.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Reg. 042760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 S. Castle St.
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 S. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Felix Kucharek

3 (b) If veteran, name war

3 (c) Social Security Account No. 213.07.0966

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Isabella Kucharek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1900

8. AGE: Years	Months	Days	If less than one day
46	2 8	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Beth. Steel Co.

FATHER
12. Name Joseph Kucharek
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Marczak
15. Birthplace Poland

16 (a) Informant Isabella Wife
(b) Address 243 S. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 10/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozaguntki
(b) Address 1930 Eastern Ave.
(c) 8-9-1946 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 1946, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to Aug 7 1946, and that I last saw h alive on Aug 7 1946.

Immediate cause of death: Pulmonary Hemorrhage — Duration 8/7/46
Due to:
Due to Pulmonary Tuberculosis — 5/1945
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William F Ryan M. D.
Address 801 Kenwood Ave Date signed 8/9/46

VS 150

C42761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

C42761 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? 60. years

3 (a) FULL NAME Minnie Echarius

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Louis Echarius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1870

8. AGE: Years 76 | Months 4 | Days 11 10 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Louis Saler
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Rebbaum
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 10. 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.

AUG 9 - 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1946 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1946 to Aug 6 1946 and that I last saw h E alive on Aug 6 1946

Immediate cause of death Cerebral Hemorrhage

Probably Thrombosis — Duration 12 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliott Dyker M.D.

Address 928 E. NORTH Ave Date signed Aug 8 1946

VS 3

12762

BALTIMORE CITY HEALTH DEPARTMENT X V 940

CERTIFICATE OF DEATH

Registered No. G12762

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore (Catonsville)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country

3 (a) FULL NAME Marie M. Mettee (MARIE MARGARET METTEE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about — 1881 —

8. AGE: Years	Months	Days	If less than one day hr.	min.
64-65 yrs.				

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

MOTHER / FATHER

12. Name Charles Andrew Mettee

13. Birthplace Balto Md

14. Maiden Name Anastasia Schuck

15. Birthplace — Balto Md.

16 (a) Informant Records Seton Institute

(b) Address 6420 Reisterstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md.

18 (a) Funeral director Stewart Mortuary Co.

(b) Address 1084 W North Ave Baltimore, Md.

AUG 9 - 1946 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1928 to August 1946, and that I last saw her alive on August 8, 1946.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Psychosis with Mental Deficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard P. Alagia M. D.

Address 23 W Frederick St Signed

X

G42763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G42763 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2310 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and name town)
(d) Street No. 2310 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C. Ritzius
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of ~~husband or~~ wife Marion J. Waggner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30 - 1870

8. AGE: Years 75 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county or state)
10. Usual Occupation Foreman (Retired)
11. Industry or business Balto. City P. D.

FATHER
12. Name Henry Ritzius
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Pretch
15. Birthplace Germany

16 (a) Informant Mrs. Edw. Connolly
(b) Address 2310 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.
(c) Rec'd by (Signature) Huntington Williams, M.D.

AUG 9 - 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8th 1946, at 2:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24, 1946 to Aug. 8, 1946 and that I last saw him alive on Aug. 7, 1946

Immediate cause of death: Carcinoma of Bladder & general metastases. — Duration: 3 Mos.
Due to
Due to
Other Conditions Angina Pectoris — 6 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward L. Connolly M. D.
Address 1643 E. North Ave. Date signed 8-9-46

M. D. R. 1939-6

G42764 HEALTH DEPARTMENT—CITY OF BALTIMORE G42764

CERTIFICATE OF DEATH

131a.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Sheridan Av. St. 10 Ward)

Registered No. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ____ yrs. ____ mos. How long in U. S. If of foreign birth? ____ yrs. ____ mos. ____ dys.

2. FULL NAME Mary Margaret Reese

(a) Residence: No. 503 Sheridan Av St., ____ Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) April 30, 1861

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
85	3	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ____ 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME Jacob Reese

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Matilda Pilgrim

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs. A Reese
(Address) 503 Sheridan Av

18. BURIAL, CREMATION, OR REMOVAL
Place CATHEDRAL Date 8-9-46 19

19. UNDERTAKER WISEFELD & SON
(Address) FAIRMOUNT AVE & 22ND ST

20. FILED AUG 10 1946 Huntington Williams M.D.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 6, 1946

22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1946 to Aug 6, 1946

I last saw h[illegible] alive on Aug 6, 1946. Death is said to have occurred on the date stated above, at 3:15 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	1943
Chronic Interstitial Nephritis	1942
Other contributory causes of importance: Arteriosclerosis	1942

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ____ Date of injury ____ 19____

Where did injury occur? ____
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ____

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify ____

(Signed) B. W. Bigby M. D.

(Address) 503 Sheridan Av

G42765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G42765 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2219 Poplar Grove St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Wittig

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-8936

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1893

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	0	18		

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Tool Maker

11. Industry or business Watchmaker

FATHER
12. Name John Henry Wittig
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ida Gorsch
15. Birthplace Md

16 (a) Informant George L Moore
(b) Address 4734 Groveland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)

(c) Cemetery or crematory Greene
Location Westminster Md

18 (a) Funeral director Wilbur Coe & Son
(b) Address

19 (Signature of local reg'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 8 1946, at 2:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to Aug 8 1946, and that I last saw him alive on Aug 7 1946.

Immediate cause of death
(a) Pulmonary Embolism
Due to (b) Coronary Occlusion
Due to (c) Arteriosclerosis

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
1 day
8 Mos
2 Yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kenneth Lazzaro
Address 1 E Thirteenth St Date signed 8/9/46

VS 150

642766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 642766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country

3 (a) FULL NAME Marion D. Williamson

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eugenia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1894

8. AGE: Years 51 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Indiana (Town, county, and state)

10. Usual Occupation Veneer Worker

11. Industry or business Own Business

FATHER
12. Name Otis Williamson
13. Birthplace Ind

MOTHER
14. Maiden Name Ida Cole
15. Birthplace N Ca

16 (a) Informant Eugenia Williamson
(b) Address 4510 Roland Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery or crematory Glen Edder Mem Pk
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1897 Pennsylvania Ave

19. AUG 10 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to August 1946, and that I last saw him alive on Aug 6 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hunt Leary M.D.
Address 2301 Madison Ave. Date signed 8/9/46

VS 150

correct age is especially important. Physicians: please write the

G42767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G42767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Winder, Carrie Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel Winder

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1878

8. AGE: Years 68 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace White Stone, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alfred Campbell
13. Birthplace Va.

MOTHER
14. Maiden Name Mollie Montague
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12, 1946 (month) (day) (year)
(c) Cemetery or crematory White Stone Va.
Location

18 (a) Funeral director George A. Kelson
(b) Address 503 P Gerstmann St

19 Aug 10 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1946, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1946, to Aug. 9 1946, and that I last saw her alive on Aug. 9 1946.

Immediate cause of death: Carcinoma of transverse colon with metastasis to liver & pancreas — Duration: MORE THAN ONE YR.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Dr. van Ackeren, Medical Director

Address Medical Officer in Charge Date signed 8/9/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G42763 ✓ G42768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 1-29 days 31
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Albemarle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank ~~Rohoda~~ Pehoda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1st 1890

8. AGE: Years	Months	Days	If less than one day
56	7	4	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marks ~~Rohoda~~ Pehoda
13. Birthplace Russia

MOTHER
14. Maiden Name Eva ?
15. Birthplace Russia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director Jos. Sagan & Son
(b) Address 1911 Eastern Ave

19 AUG 10 1946 (Date rec'd by registrar) Hamilton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5th 1946, at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8th 1943 to Aug. 5th 1946 and that I last saw him alive on Aug. 5th 1946.

Immediate cause of death: Coronary occlusion — Duration 10 min.

Due to

Due to

Other Conditions Bilateral leg amputation

(Include pregnancy within 3 months of death)

Date of operation 1943 & 1945

Major findings of operation: Gangrene of both feet

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hosps Date signed 7-3-46

(over)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G42769 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Ave
(c) Hospital or institution: — 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Union Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Hilger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Eugene F. Hilger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1870

8. AGE: Years 76 Months 4 Days 10 If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER 12. Name William H. Baxter

13. Birthplace —

MOTHER 14. Maiden Name Martha J. Possey

15. Birthplace Virginia

16 (a) Informant Mrs. Virginia Roberts

(b) Address 6309 Harford Rd Glen Echo Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10 1946 (month) (day) (year)

(c) Cemetery or crematory Dr. Mary A. Hampden

Location Baltimore, Md

18 (a) Funeral director Burgee Funeral Home

(b) Address 2046 Gay Street

AUG 10 1946 (Date rec'd by registrar)

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1946, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1946, to Aug 7 1946, and that I last saw h. alive on 8-7 1946.

Immediate cause of death: Myocardial Insufficiency — Duration: 2 days

Due to: Arteriosclerosis — 10 yrs.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Arthur B. Davis M. D.

Address 8001 Eastern Ave Date signed 8-9-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G42770 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G42770

CERTIFICATE OF DEATH 46B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward A. Green Est.
(c) Hospital or institution: Asyl. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Marietta Kelly
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Widow

6 (b) Name of husband or wife — 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 31, 1879

8. AGE: Years	Months	Days	If less than one day
67	4	9	hr. — min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Wm. H. Wesley
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Cromwell
15. Birthplace Md.

16 (a) Informant Mr. Elva S. Downs
(b) Address Linthicum Heights, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/46 (month) (day) (year)
(c) Cemetery ~~Crematory~~ Friendship
Location Camp Meade Rd., Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Date received by Local Registrar AUG 10 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1946, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2/46 19 to 8/9/46 19 ; and that I last saw h[illegible] alive on 8/9 1946

Immediate cause of death Resp. failure

Due to Generalized Carcinomatosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: None
of autopsy: None

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Thomas Nichols M.D.
Address Univ. Hosp. Date signed 8/9/46

X

842771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Register No. 842771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-7-8
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5-10 Old Orchard Rd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr George Waltz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Mrs Ada Waltz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21, 1866

8. AGE:	Years	Months	Days	If less than one day
	79	9	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None at present
11. Industry or business

FATHER
12. Name Charles Wm. Waltz
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Stake
15. Birthplace Md.

16 (a) Informant Mrs. Ada Fetting Waltz
(b) Address 680 Riverside Drive, N. Y. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) AUG 10 1946 (Filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 19 46, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 19 46 to Aug 8 19 46, and that I last saw h e alive on Aug 8 19 46.

Immediate cause of death Pneumonia
Gailure

Duration

Due to Cardio-renal disease

Due to Generalized arteriosclerosis.

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Lass M. D.
Address Bon Secours Hospital Date signed 8/8/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G427:12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registration No. G427:12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 Sheridan Ave
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 SHERIDAN.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Hudnall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 73 | Months - | Days | If less than one day hr. min.

9. Birthplace Sumter S. C.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name John Cole

13. Birthplace Sumter S.C.

MOTHER 14. Maiden Name Cole

15. Birthplace

16 (a) Informant Ruth Hudnall

(b) Address 530 Sheridan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-46 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet S.C.

Location Sumter, S.C.

18 (a) Funeral director Wiedefeld & Son

(b) Address Mount Ave & 22nd St.

19 AUG 10 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 August 1946, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of skull with cerebral hemorrhage

Due to

Other Conditions Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8/9/46 at 27/10 3-4 A. M.

(b) Where did injury occur? 530 Sheridan Ave

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury Fell down stairs inside home

23. Signature Wm. H. Ramme, Jr. M.D. Medical Examiner.

Date signed 9 August 1946

VS 151

G42713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G42713

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Canterbury Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary C. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife JOHN J. WHITE

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) ~~1870~~ 1866

8. AGE: Years	Months	Days	If less than one day
80 76			hr. min.

9. Birthplace Wilmington, Delaware (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name John Payne

13. Birthplace IRELAND

14. Maiden Name Susan Payne.

15. Birthplace IRELAND

16 (a) Informant DR. THOMAS WHITE.

(b) Address 3908 CANTERBURY RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-12-46 (month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRAL.

Location WILMINGTON, DEL.

18 (a) Funeral director WIEDEFELD & SON

(b) Address [illegible] MOUNT LEE AVE. & HOWARD ST.

19 AUG 10 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1944 to August, 1946, and that I last saw her alive on August 8, 1946.

Immediate cause of death: Myocardial Infarct — Duration 2 Mths

Due to

Due to

Other Conditions arteriosclerosis ? Senile Psychosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damon H. Palay M. D.

Address 23 W. Preston St. Date signed

VS 150

G42774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G42774

Ed. 103537

Write the causes of death clearly and legibly. Physicians: please write to correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) N.B
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 W. Montgomery St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Byrd Baby Girl (Mary)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7th 1946

8. AGE: Years | Months | Days | If less than one day hr. 30- min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Isrel Barnett
13. Birthplace N .C

MOTHER 14. Maiden Name Mary Baker
15. Birthplace S. C .

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-8-46 at 9.00 A M (month) (day) (year)
(c) [redacted] crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

19 AUG 10 1946 (b) Huntington W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7th 1946 at 1.07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 7 19 46 to Aug. 7 19 46
and that I last saw h im alive on Aug. 7 19 46

Immediate cause of death	Duration
atelectasis, pulmonary	
Due to Premature	
Due to	
Other Conditions Infantum Fever 7 hrs	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.

Address City Hospital Date signed 8 Aug 46

VS 150

G42775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G42775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Willow Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Willow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Smithcum Crise

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-18-5002

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 31-1884

8. AGE: Years 62 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER 12. Name JOHN L. CRISE
13. Birthplace MARYLAND

MOTHER 14. Maiden Name MALINDA RABORG
15. Birthplace MARYLAND.

16 (a) Informant HOWARD L. CRISE
(b) Address 511 WILLOW AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 10-46 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT
Location BALTO-MD

18 (a) Funeral director O'Donnell Funeral Home Inc
(b) Address 4644 YORK RD.

19 AUG 10 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1946 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1946 to Aug 8 1946 and that I last saw h alive on Aug 8 1946

Immediate cause of death: Cerebral Thrombosis — Duration 3 mo.
Due to Ch. Hypertension
Due to Arteriosclerosis.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Harding M. D.
Address 4810 Belair Rd Date signed Aug 9 '46

G42776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G42776

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Greene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Julian Greene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1906

8. AGE: Years 39 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Orange Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Simon Robinson.
13. Birthplace Orange, Va..

MOTHER
14. Maiden Name Mattie Towns.
15. Birthplace Orange, Va.

16 (a) Informant Julian Greene
(b) Address 1134 W. Lexington St

17 (a) Aug. 10, 1946 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St
(c) Signature of registrar Huntington Williams, M.D.

AUG 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1946, at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1946 to Aug 7 1946 and that I last saw her alive on Aug 6 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	9 hours
Due to Essential Hypertension	unknown
Due to	
Other Conditions Carcinoma of Liver	unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald M. D.
Address 844 Cary St Date signed 8/9/46

VS 150

G42777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G42777

Please write the causes of death clearly and legibly. Physicians: please correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Bank Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Bank Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Zofia Nadolny (Nadolski)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Peter Nadolny
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1890

8. AGE: Years	Months	Days	If less than one day
56	3	2	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Kozlawski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs Victoria Rympalski
(b) Address 1908 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County
18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street
19 AUG 10 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 5 45

20. DATE OF DEATH Aug 7, 1946, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1946, to Aug 7th 1946 and that I last saw him alive on Aug 7th 1946

Immediate cause of death	Duration
(a) Cardiac Hemiplegia	2
Due to Hypertension	
(b) arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature H. A. Jamison M. D.
Address 100 N. McElroy Date signed 8/12/46

G42778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 140a

Registered No. G42778

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 22 S. Green St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 St. Dunstans Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Hartlove

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Wilmer Hartlove
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) May 29th 1913

8. AGE: Years	Months	Days	If less than one day
33	2	11	hr. min.

9. Birthplace Queen Anne Co Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Clerk

FATHER
12. Name Geo Caton
13. Birthplace Md

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Md

16 (a) Informant Wilmer Hartlove
(b) Address 602 St Dunstans Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) Filed AUG 10 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9/46 19 , at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1946 to 8/9/1946 and that I last saw her alive on 8/9/1946

Immediate cause of death Respiratory Failure.
Due to Stock.
Due to
Other Conditions Diab. Mell. 5 yrs.
Hypertension
(Include pregnancy within 3 months of death)

Duration

Date of operation 3 Aug. Low Subtotal Thyroid
Major findings of operation: Perforation of small bowel.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles O'Donnell Jr. M. D.
Address University Hospital Date signed 8/9/46

VS 150

G42779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G42779

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 E. Chase St.
(c) Hospital or institution:
at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 932 E Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn Regina Farrelly

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1897

8. AGE: Years 48 Months 10 Days 21 If less than one day hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Grocery Cash Meat

FATHER 12. Name Michael J. Farrelly

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret A. McCabe

15. Birthplace Ireland

16 (a) Informant Mrs. Wm. H. Farrelly

(b) Address 932 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1946 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem. Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Carter & Son

(b) Address 924 E. Eager St.

AUG 10 1946 (Date received by local registrar) Washington Williams (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1946, at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1946, to Aug 9, 1946, and that I last saw h. 9e alive on Aug 8, 1946.

Immediate cause of death

Carcinoma of Liver — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury KENNARD YAFFE

23. Signature Kennard Yaffe MD

Address 3711 W Belvedere Ave Date signed 8/9/46

642780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 642780

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Ken Oak Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Ken Oak Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Elnora Hart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Harry C. Hart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Street
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Sarah Blain
15. Birthplace York Co. Pa.

16 (a) Informant Mr Wm H. Hart
(b) Address 3000 Ken Oak Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-46 (month) (day) (year)
(c) Cemetery or crematory Glade Ridge Cem.
Location Delta, Pa.

18 (a) Funeral director Loring Byers
(b) Address 505 Park Ave.

19 (a) AUG 10 1946 Huntington Williams M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1946 at 4A. M about

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1st 1946 to Aug 8 1946 and that I last saw h[illegible] alive on Aug 8th 46

Immediate cause of death Arteriosclerosis Coronary Disease with Cardiac Decompensation - Duration

Due to Decompensation - Duration

Due to Fibrillation

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mitchell Boyarsky M.D.
Address 410 Medical Arts Bldg Date signed 8/10/46

X

G42781 (over) 498607.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

Registered No. G42781

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Mierkiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-17-46

8. AGE: Years | Months 2 3 | Days 24 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Albert Mierkiewicz
13. Birthplace Md

MOTHER 14. Maiden Name Stella Slepczuk
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-46 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 S Arrington Washington, Md

19 (c) AUG 10 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-10 1946, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-8 1946, to Aug-10 1946, and that I last saw h alive on Aug-10 1946.

Immediate cause of death: Tumor choroid plexus - post operative shock — Duration 1h

Due to

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation August 9, 1946
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dorothea S. Froggatt M. D.
Address Johns Hopkins Hospital Date signed 8/10/46

VS 150

G42782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G42782 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3430 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3430 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas J. Scheenig

3 (b) If veteran, name war

3 (c) Social Security Account No. 219 10 9374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marie F. nee Starke 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1873.

8. AGE: Years	Months	Days	If less than one day
73		22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business A. Hoen & Co.

FATHER
12. Name Joseph M. Scheenig
13. Birthplace Germany

MOTHER
14. Maiden Name Appolonia Nothas
15. Birthplace Md.

16 (a) Informant Mrs. Marie F. Scheenig
(b) Address 3430 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12/46. (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Belair Rd., Baltimore, Md.

18 (a) Funeral director Harry F. Kutzler
(b) Address 4101 Edmondson Ave.

19 AUG 10 1946 (a) Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 11 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1946 to Aug 8 1946 and that I last saw h alive on Aug 8 1946

Immediate cause of death
Due to Cardiac Dilatation
Amputation Right Lgt Thigh
Due to Coronary Thrombosis

Duration
8-5-46
4-24-46
4-6-46

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4-24-46
Major findings of operation Gangrene of Right leg & thigh
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 7026 E. North Ave. Date signed

VS 150

G42783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G42783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1360 Cleveland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Anne Webeza

(b) Address 1360 Cleveland St

17 (a) Burial (b) Date thereof 8/10/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1100 Brant Lane

19 (a) (b) Huntington Williams M.D.

AUG 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Aug 1946 at 6 60 M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner

Date signed 2 Aug 46

C12784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. C12784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Dallas st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Scott Holt

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex: Colored | 5. Color or race: Male | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1890

8. AGE: Years 56 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Newport News Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Sherman Holt

13. Birthplace Newport News

MOTHER 14. Maiden Name Rose ?

15. Birthplace Va.

16 (a) Informant Florence Holt

(b) Address 1512 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13/46 (month) (day) (year)

(c) Cemetery or crematory Balto. Nat. ~~Comp~~ Cemetery

Location ~~Balto County~~ Md.

18 (a) Funeral director Mrs. Pott & Elliott, Dyer

(b) Address 129 N Carolina St.

19 (a) AUG 10 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 August 1946, at 2.40 A.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer Jr. M.D. Medical Examiner.

Date signed 9 Aug. 1946

VS 151

G42785

BALTIMORE CITY HEALTH DEPARTMENT ✓ 50

CERTIFICATE OF DEATH

Registered No. G42785

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 N. Milton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Butera

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Gerlando Butera
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1865

8. AGE: Years	Months	Days	If less than one day
81 yrs.	6	8	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name
15. Birthplace "

16 (a) Informant Anthony DeMagio - son
(b) Address 809 N. Milton Avenue

17 (a) Burial (b) Date thereof 8/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) AUG 10 1946 Huntington Williams, M.D.
(Signature of registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9, 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7- 1946, to 8-9- 1946, and that I last saw h M alive on 8-9- 1946

Immediate cause of death: CARDIAC FAILURE — Duration: 3 Days

Due to CANCER OF BREAST WITH METASTASES — 2 YRS.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Mora M.D. M. D.
Address 448 N. Luzerne Ave Date signed 8-10-46

G42786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G42786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 W. Fulton
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 W. Fulton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER PRICE SR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 203-03-5563

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife Sarah A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1880

8. AGE: Years 66 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Taylor Pa.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Schenuit Rubber Co.

FATHER
12. Name Unknown
13. Birthplace -

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Davis & Sultzer
(b) Address Taylor Pa.

17 (a) Removal (b) Date thereof 8/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Home
Location Taylor Pa.

18 (a) Funeral director Wm Cook Jose
(b) Address 1212 St Paul St

19 (a) AUG 10 1946 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/46 19 , at 4 00 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 8/10/46

VS 151

G12787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G12787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don't Know
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Balto
(If outside city or town limits, write Rural, and give town)
(d) Street No. 414 E 31st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Geblein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4-1899

8. AGE: Years 46 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Upholster

11. Industry or business Self

FATHER 12. Name George Geblein

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Margaret ?

MOTHER 15. Birthplace Germany

16 (a) Informant Rosa Geblein

(b) Address 414 E. 31st St

17 (a) Burial (b) Date thereof 8/13/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem
Location Parkville

18 (a) Funeral director Wm Cook Inc.

(b) Address 212 St Paul St

19 AUG 10 1946
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Aug 1946, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William Y. Hefflefinger M.D.
Medical Examiner

Date signed 10 Aug 46

VS 151

42788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G42788 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State West Virginia
(c) City or town McComas
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Jane Walker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Alta Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-97

8. AGE: Years	Months	Days	If less than one day
49	7	19	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Henry Sefroder
13. Birthplace W. Va.

MOTHER 14. Maiden Name Catharine Hill
15. Birthplace n. a.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-46 (month) (day) (year)
(c) Cemetery or crematory Bluefield W. Va.
Location C.F.M. Woodlawn

18 (a) Funeral director Wm. C. Miller Sons
(b) Address 2435 E. Olin Ave

19 AUG 10 1946 (c) Filed (d) Registrar Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9-1946 at 4.40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 7-31 1946 to 8-9 1946 and that I last saw h alive on 8-9 1946.

	Duration
Immediate cause of death: Bronchopneumonia	1 day
Due to: Agranulocytosis	2 months
Due to: Leukemia	10 months
Other Conditions: Ludwig's Angina	2 weeks

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas B. Carroll
Address Johns Hopkins Hosp Date signed 9 Aug 46

VS 150

G42789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G42789 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Aisquith
(c) Hospital or institution:
Convent of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr.M.Viola Magin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/1871

8. AGE: Years	Months	Days	If less than one day
75	1	17	hr. min.

9. Birthplace Rochester N.Y. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business Religious

FATHER
12. Name Martin Magin
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Englert
15. Birthplace Germany

16 (a) Informant Sr.M.Stan.Kostka
(b) Address 901 Aisquith

17 (a) Burial (b) Date thereof Aug 12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Glen Arm

18 (a) Funeral director Geo M. Smith & Son
(b) Address 8 W. Washington St. Hagerstown, Md.

AUG 11 1946

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 46 19 , at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945, to Aug. 9 1946, and that I last saw her alive on Aug. 8 1946.

Immediate cause of death Inoperable Carcinoma cervix — Duration

Due to Fracture neck of femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8/1/46 at 9 a. M
(c) Where did injury occur? 901 Aisquith Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Convent (Specify type of place) While at work? No
(e) Means of injury Injured on floor in bath room

23. Signature [illegible]
Address 110 E Northern Ave Date signed 8/10/46

VS 150

G42790 BALTIMORE CITY HEALTH DEPARTMENT G42790

CERTIFICATE OF DEATH

5-9-12

Please write the causes of death clearly and legibly. Physicians: please write the exact age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 Chapel Gate Lane
(c) Hospital or institution:
Pine Crest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town North Linthicum
(If outside city or town limits, write RURAL and give town)
(d) Street No. Nursery Rd. & Old Annapolis Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Burns

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 6, 1901

8. AGE: Years 45 | Months 2 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Basil R. Burns
13. Birthplace Maryland

MOTHER
14. Maiden Name Alvina F. Brandenburg
15. Birthplace Maryland

16 (a) Informant: Edward R. Burns
(b) Address North Linthicum, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) Date received AUG 13 1946 (b) Registrar Huntington Williams M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1946, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 9 1946 and that I last saw h. alive on Aug 9 1946

Immediate cause of death: Cardio Vascular Collapse — Duration: 4 days
Due to
Due to
Other Conditions: Ischemic Dementia, Hemiplegia, Arthritis spine — Duration: 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Calagna M.D.
Address 336 Frederick Ave. Date signed 8/9/46

G42791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G42791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Mc Culloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F. Stanley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Josephine
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 1894

8. AGE: Years 52 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Frederick Md. (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business

FATHER 12. Name John F. Stanley Sr.
13. Birthplace Md

MOTHER 14. Maiden Name Caroline ?
15. Birthplace Md.

16 (a) Informant Josephine Stanley
(b) Address 818 Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A & A County Md

18 (a) Funeral director Mc Cliff Elmore
(b) Address 1129 N. Carrollton St

19 (a) Filed by registrar Washington Williams, M (b) Date filed AUG 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1946, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Aug 7 1946 and that I last saw h[illegible] alive on Aug 7 1946

Immediate cause of death Uremia — Duration

Due to Hypertension

Due to (Chronic Nephritis (Nephrosclerosis)

Other Conditions Marked Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emerson R. Julian
Address 434 E. 23rd St Date signed 8/10/46

Write age if under 1 year. Physicians: please write the causes of death clearly and legibly.

T 1 1946

VS 150

G42792 BALTIMORE CITY HEALTH DEPARTMENT G42792

CERTIFICATE OF DEATH 61

Registered No.

please write the causes of death clearly and legibly. Physicians: please note that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or Institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If not in city or town limits, write RURAL, and give town)
(d) Street No. Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Muller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced W
6 (b) Name of husband or wife Michael
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870
8. AGE: Years 76 Months Days If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Menzel
13. Birthplace Poland

MOTHER
14. Maiden Name Burbat
15. Birthplace Poland

16 (a) Informant Next Of Kin
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hwy & Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St

19 (a) 8 11 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1946 to 8-11 1946 and that I last saw her alive on 8-11 1946.

Immediate cause of death: Hypertension Arterio sclerosis, Diabetes — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Kleven
Address Levindale Date signed 8/12/46

VS 190

X

G42793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G42793 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 S. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 S. Smallwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-7294

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth - Miller
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 6 Mar. 1893

8. AGE: Years	Months	Days	If less than one day
53	5	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Consol. Gas & Electric Co

FATHER
12. Name Henry H. Miller
13. Birthplace Maryland.

MOTHER
14. Maiden Name Minnie Vogt
15. Birthplace Maryland.

16 (a) Informant Mrs. Elizabeth Miller
(b) Address 423 S. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-Aug-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. B. Shiffert & Son
(b) Address 1300 Eutaw Place.

19 Aug 11 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 August 1946, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1946 to Aug 8 1946 and that I last saw h. alive on Aug 8 1946.

Immediate cause of death
Pulmonary Tuberculosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1724 W. Lombard St. Date signed Aug 10 46

VS 150

G42794 ✓ G42794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland and Rayner Aves.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 E. Biddle St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Doud

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife John H. Doud
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1875

8. AGE: Years 71 | Months 3 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Dolan
13. Birthplace IRELAND

MOTHER 14. Maiden Name Elizabeth Dolan
15. Birthplace IRELAND

16 (a) Informant Son
(b) Address 1638 Abbottston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

19 (a) Filed by registrar 1946 (b) Registrar Washington Millikan, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Aug 1946, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Aug 1946, to 9 Aug 1946, and that I last saw her alive on 9 Aug 1946.

Immediate cause of death	Duration
Respiratory Failure	2 days
Due to Bronchopneumonia	3 days
Due to Fracture Left Femur	9 days
Other Conditions Diabetes Mellitus, Hypertension Cardiovascular Disease (Include pregnancy within 3 months of death)	Years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1 Aug '46 at 7:00 P M
(c) Where did injury occur? Baltimore City (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell off Commode
23. Signature J. W. Bell
Address N. 32d St. Balto. Gen. Hosp. Date signed 9 Aug 46

For Dorothy A. Kammer, by Howard J. Whatton, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G42795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G42795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 Light St.
(c) Hospital or institution: South Balto. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore # 26.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Poplar St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nellie H. Stolarski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Thomas Stolarski
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 10-21-13

8. AGE: Years 32 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation House wife.

11. Industry or business

FATHER 12. Name Adam Wakeski

13. Birthplace Europe

MOTHER 14. Maiden Name Anne Kulis

15. Birthplace Europe.

16 (a) Informant Thomas Stalarski

(b) Address 1523 Poplar St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-46 (Month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Pulaski Highway

18 (a) Funeral director Charles H. Fidelmansdorf

(b) Address 208 McHenry St

19 (a) AUG 12 1946 (b) Huntingtown Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1946 to 8-8 1946; and that I last saw her alive on 8-8 1946.

Immediate cause of death: Acute Hemorrhagic Nephritis — Duration

Due to

Due to

Other Conditions: Gangrenous Pedunculated Fibrosis of Uterus Cervix
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify typical Place)
(e) Means of injury

23. Signature Herbert F. Spindel M.D.
Address 104 Belto. Gen'l Hosp. Date signed 8-9-46

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2796 394522

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G42796
Registered No.

CERTIFICATE OF DEATH 15 7E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Harmon City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 131
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carole Wigle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-42

8. AGE: Years 4 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Harmon City Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Norman Wigle
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Sybil Harder
15. Birthplace Pennsylvania

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Burial

17 (a) Authorized (Burial, cremation, or removal) (b) Date thereof Aug (12-46 (month) (day) (year)

(c) Cemetery or crematory Leon Lincoln Mem. Park
Location GREENBERG, PA

18 (a) Funeral director John D. Mitchell
(b) Address 1200 Eutaw Pl.

AUG 12 1946 (Date rec'd by local registrar) (b) Huntingdon Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946, at 20 29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946, to Aug 11 1946, and that I last saw him alive on Aug 11 1946.

Immediate cause of death: Cerebral Thrombosis — Duration 24 Hrs.
Due to: Congenital Heart Disease - Tetralogy of Fallot — Duration Life
Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8/10/1946

Major findings of operation: Tetralogy of Fallot

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. D. Ruben
Address J.H.H. Date signed 8/11/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G42797 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 159

G42797 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St., 23-
(c) Hospital or institution:
Bon Secours Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 S. Patterson Park Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard (Francis) Frank Owens Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1946

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Bernard Frank Owens
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sonia Dolores Malasek
15. Birthplace Baltimore

16 (a) Informant Bernard Frank Owens (Father)
(b) Address 400 S. Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave

19 (a) AUG 12 1946 Registrar
(b) Registered number
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946, to Aug 10 1946, and that I last saw h[illegible] alive on Aug 10 1946.

Immediate cause of death	Duration
Respiratory paralysis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. F. Sass M. D.
Address 3 Bon Secours Apts. Date signed 8/11/46

X

G42798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G42798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4716 Roland Ave.
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4715 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Theresa Chandlee

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1873

8. AGE: Years 72 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore - maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Henry F. Chandlee
13. Birthplace Cecil Co, Md.

MOTHER
14. Maiden Name Catharine Gaw
15. Birthplace Ellicott City - Md.

16 (a) Informant Miss Helen R Chandlee (sister)
(b) Address 4715 Roland Ave., City - 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 - 12 - 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. City, Md.

18 (a) Funeral director Stewart & Bowen Co.
(b) Address 108 W. North Ave. - Balto.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 130 AUG 12 1946 Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Aug 46 19 , at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Aug 1946 to 10 Aug 1946, and that I last saw h.. alive on 10 Aug 1946.

Immediate cause of death: Arteriosclerotic Cardio Vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F Kelsch M. D.
Address 500 6 Roland Ave Date signed 10 Aug 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

G42799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 W. Fayette
(c) Hospital or institution: Bon Secours Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 S. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Edelmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-78

8. AGE: Years 68 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mildred Edelmann
(b) Address 1006 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/46 (month) (day) (year)
(c) Cemetery or crematory Loved Rest
Location German Hill Rd

18 (a) Funeral director Selby & Zeile, Inc
(b) Address 4008 Eastern Ave

19 (a) AUG 12 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1946 at 8:2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31 1946, to 8-10 1946, and that I last saw her alive on 8-10 1946.

Immediate cause of death: Sarcoma (Duration)
(Interval between onset and death)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Solomon M. D.
Address Bon Secours Hosp Date signed 8-10-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G42800 · BALTIMORE CITY HEALTH DEPARTMENT X ✓ G42800

498602. CERTIFICATE OF DEATH 72B Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Owndalk. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7546 Holabird Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Joseph Boone.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	White.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-32

8. AGE: Years	Months	Days	If less than one day
14.	2	3/	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Schoolboy
11. Industry or business

FATHER
12. Name George Boone
13. Birthplace W. Va.

MOTHER
14. Maiden Name Augusta
15. Birthplace Ind.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 12/46 (month) (day) (year)
(c) Cemetery or crematory Maplewood Home
Location Ridgewood W. Va.

18 (a) Funeral director Phillips Stewart Sons
(b) Address 2624 Orleans St.

19 (a) (Date rec'd by registrar) (b) Huntington, W. Va.

AUG 12 1946

MEDICAL CERTIFICATION E

20. DATE OF DEATH Aug. 9 1946 at 10.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8. 1946 to Aug. 9 1946 and that I last saw living alive on Aug. 9 1946

Immediate cause of death	Duration
Reaction to Mecholyl	1 min.
Due to	
Due to	
Other Conditions Hemophilia Urinary retention 1 day (Include pregnancy within 3 months of death)	14 yrs.

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Lee Randol
Address Johns Hopkins Hospital Date signed 8/10/46

G42801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. G42801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3134 St
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4414 NORWOOD RD. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK FISHER JR.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED.

6 (b) Name of husband or wife MRS. SARAH PARKER FISHER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1877

8. AGE: Years	Months	Days	If less than one day
69 68	5	20 19	hr. min.

9. Birthplace WASHINGTON, D.C. (Town, county, and state)
10. Usual Occupation STOCK BROKER
11. Industry or business

FATHER
12. Name JOHN HARMANUS FISHER
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name JOSEPH MC CULLOUGH
15. Birthplace HAITTI

16 (a) Informant MRS. FRANK FISHER.
(b) Address 4414 NORWOOD RD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Henry W. Eastern Sons Co
(b) Address McCulloh & Preston Sts

AUG 12 1946 (Date rec'd by registrar) (b) Huntington Williams Mgr. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Aug 1946, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1946 to Aug 11 1946, and that I last saw him alive on Aug 11 1946.

Immediate cause of death: CARCINOMA OF PANCREAS — Duration

Due to

Due to

Other Conditions DIABETES MELLITUS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr.
Address Union Memorial Hosp. Date signed Aug 13 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G4280.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1222

Registered No. G4280.2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. Universanty Pkwy (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Hardy Charles Gieske

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Married

6 (b) Name of husband or wife Mrs Evelyn Gieske
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	21	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Tobacco broker
11. Industry or business

FATHER
12. Name Gustav Gieske
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Driver
15. Birthplace Germany

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W. Eugene Sloan
(b) Address McCulloh & Eutaw Sts

19 Aug 12 1946 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1946, at 2 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Cerebro-vascular accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-25-46

Major findings of operation: Strangulated femoral hernia rt

Autopsy? Return of Coroner attached

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kilpatrick Jr. M.D.
Address Union Memorial Hosp Date signed 8-9-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G12803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Latrobe Apts.
(c) Hospital or institution: Charles & Read Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Latrobe Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Genevieve Leland Blodget Duer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Douglas H Duer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1852

8. AGE: Years 93 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Boston, Mass. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Townsend Blodget
13. Birthplace Randolph, Vt.

MOTHER
14. Maiden Name Lucretia Wheelwright Wood Leland
15. Birthplace Mendon, Mass.

16 (a) Informant Henry T. Duer
(b) Address Mayfield Woodbrook, Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address Mc Culloh & Richard Sts

19 AUG 12 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1946 to Aug 10 1946 and that I last saw h alive on Aug 9 1946.

Immediate cause of death: Myocarditis Arterio-Sclerosis — Duration: Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H Brady M.D.
Address 1403 Eutaw Pl Date signed 8/10/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

G42804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1490

Registered No. G42804

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
State Md. (b) County
(c) City or town Baltimore - 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Neal

S39731

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife William H. Neal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name James Craig.
13. Birthplace West Indies

MOTHER 14. Maiden Name Neal
15. Birthplace

16 (a) Informant William Neal
(b) Address 967 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Hurleme
Location Baltimore - Md.

18 (a) Funeral director MP: Frances A. Hayesley
(b) Address 5786 W. Biddle St.

19 (a) Date received AUG 12 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Aug 1946 at 11 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1946 to 8-9 1946, and that I last saw h. alive on 11 50 P.M 8-9-46

Immediate cause of death: Pulmonary Edema — Duration

Due to Cardiac dilatation due to uterus, fibroma, ruptured & complete — Duration

Due to Hemorrhagic shock, due to fibroma, uterus, ruptured & complete — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-6-46

Major findings of operations: Ruptured fibroma uterus, complete

of autopsy: 8-10-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James H. Dean M. D.
Address Univ. Hosp. Date signed 8-10-46

G42805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 30

G42805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Penn. Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Peggy ADELE Welch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	MARRIED

6 (b) Name of husband or wife ALFRED.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-22-1900

8. AGE: Years	Months	Days	If less than one day
46	5	18 17	hr. min.

9. Birthplace Phila Pa. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business CAMP HOLLABIRD

FATHER
12. Name Milton Blake
13. Birthplace D.C. Md

MOTHER
14. Maiden Name Mamie Phoenix
15. Birthplace D.C

16 (a) Informant Wm Blake
(b) Address 1625 Susan St. Phila Pa

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8-12-46 (month) (day) (year)
(c) Cemetery or crematory Philadelphia Penna
Location Philadelphia Penna

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1946, at 5:49 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1946 to Aug. 9 1946. and that I last saw he alive on Aug 9. 1946.

Immediate cause of death: Pulmonary failure — Duration 2 weeks (Estimated)
Due to Uremia
Due to Acute glomerular Nephritis
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James E R Tureman
Address President Hosp Date signed 8-11-46

St. Timothy Williams, M.D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G42806
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 No Payson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1824 No Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Winik

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 50 | Months | Days | If less than one day: hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mortaj
13. Birthplace Lith

MOTHER
14. Maiden Name Dulbrey
15. Birthplace Lith

16 (a) Informant Harry Winik
(b) Address 1824 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-46 (month) (day) (year)

(c) Cemetery or crematory Workman Circle
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Md (Signature of registrar)

VS 15 AUG 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11-1946 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Aug 11 1946, and that I last saw h alive on Aug 11 1946.

Immediate cause of death	Duration
(a) Acute Myocardial Failure	1 day
due to (b) Pulmonary Edema	unknown
Due to Chronic Myocarditis & Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Workman MD
Address 1921 W North Date signed 8/12/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

Registered No. G42807

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Aged Men + Womens Home
(c) Hospital or institution: 1302 W. Lexington St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Burgundy St. (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Towzer

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Divorced

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 7th 1883

8. AGE: Years	Months	Days	If less than one day
63	5	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name Thomas Ward
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary
15. Birthplace England

16 (a) Informant Mrs Kathleen Schellenberg
(b) Address 1154 Carroll St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug 13th 1946 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem
Location 1300 Mosland Ave.

18. (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

AUG 12 1946 (Delivered by) (b) Huntingdon Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9th 1946, at 10 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1946 to Aug 9 1946 and that I last saw h alive on 1946

Immediate cause of death: Pneumonia, fibrillation

Duration

Due to 1

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Kramer M.D.
Address 1424 W. Fayette St Date signed 8/10/46

VS 150

Siscovick

G42808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G42808 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1081 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1081 W. Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine S. Chaffinch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/1865

8. AGE: Years	Months	Days	If less than one day
81	6	8	hr. min.

9. Birthplace Baltimore — Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name William Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Anna J Pickel
15. Birthplace Germany

16 (a) Informant Mary Fischer
(b) Address 1081 W Lexington

17 (a) Burial (b) Date thereof Aug 13
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Lucian Funeral Home
(b) Address 2008 Arlington St

19 (a) (b)
(Date rec'd by registrar) Registrar

AUG 12 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1946 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1946 to 8/9 1946 and that I last saw h alive on 8/8 1946

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Trawler M. D.
Address 1111 Eutaw Pl Date signed 8/10/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G42809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Carroll Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Homestead
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Oliver Hutson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence Ida Metz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31, 1883

8. AGE: Years 62 | Months 11 | Days 22 9 | If less than one day hr. min.

9. Birthplace Baltimore, Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Engineer (Yacht Builder)

11. Industry or business Ship Building

FATHER
12. Name John T. Hutson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Catherine (?)
15. Birthplace Baltimore, Maryland.

16 (a) Informant (son) William Hutson
(b) Address 706 Carroll Street, Balto-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Rucke
(b) Address 5305 Hartford Rucke

19 (a) (Date received by Registrar) AUG 12 1946 (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1946 19 ..., at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 2, 1946, to August 9, 1946, and that I last saw him alive on August 9, 1946.

Immediate cause of death: Acute Right Heart Failure — Duration: 2 hours
Carcinoma Metastatic left lung — 3 years
Due to
Due to
Other Conditions: Left Hemiplegia (Metastatic cerebral embolism) — 8 months
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 651 N. Bentalou Str. Date signed 8/9/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G42810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Church St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Church St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ignacy Rusul (adam Rosul)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Stanislawa
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business Boston Iron & Metal

FATHER
12. Name Michal Rosul
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Stanislawa Rosul
(b) Address 1612 Church

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. D. Fiallkowski
(b) Address 2007 Eastern Ave

19 (a) Aug 12 1946 (b) Registrar's signature Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1946 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to Aug 8 1946 and that I last saw h alive on 19

Immediate cause of death: Uremia Cardiac Failure Chronic Nephritis

Duration
6 mos
5 days

Due to Diabetes Mellitus

Due to

Other Conditions Hypertension Coronary Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 19 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon A. Upshur M. D.
Address 1720 Pennsylvania Ave
Date signed Aug 10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G42811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. G42811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Fleet St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislaw Siemek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Newton Paper Box Co

FATHER
12. Name John Siemek
13. Birthplace Poland

MOTHER
14. Maiden Name Alice Brozdowska
15. Birthplace Poland

16 (a) Informant Anna Siemek
(b) Address 2001 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fiallkowski
(b) Address 2007 Eastern Ave

19 (a) (Date received by registrar) AUG 12 1946 (b) Registrar Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1946 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased since ... 1944 to ... 19 ... and that I last saw h[illegible] alive on Aug 9-46

Immediate cause of death

Duration: Aug. 9

Coronary Thrombosis

Due to Cardiac Infarct 2

Probably contracted

Due to on 1st Coronary Attack in June 1944.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M.D.

Address 1732 N. Broadway Date signed Aug 12 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G42812 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ G42812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Coolidge
(b) Street address St Joseph
(c) Hospital or institution: St Josephs Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3154 Rauswood Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Carola Patricia Schmidt

3 (b) If veteran, name war: **
3 (c) Social Security Account No. **

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 | 10 | 46

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

FATHER
12. Name Leonard August Schmidt
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Leota Blanche Boswell
15. Birthplace Baltimore Md.

16 (a) Informant Leota Blanche Schmidt
(b) Address 3154 Rauswood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

AUG 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1946 at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 10 1946 to 8/11 1946 and that I last saw h[illegible] alive on 8/11 1946

Immediate cause of death Cardio-Respiratory failure — Duration

Due to Prematurity. 26 wks gestation. Twin

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruby Cadar M.D.
Address [illegible] Date signed 8/11/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42813
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution:
Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. & Dundalk Aves.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ALICE GRACE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John T. Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1862

8. AGE: Years	Months	Days	If less than one day
83	10	28	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Wilkinson
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Mary E. Galloway
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. William G. Lynch
(b) Address 3011 Dunglow Rd.

17 (a) Burial (b) Date thereof 8/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 AUG 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1946 at 8:50a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1946 to Aug. 10 1946 and that I last saw her alive on Aug. 9 1946.

Immediate cause of death: Cardio-Respiratory Failure, Hypostatic Pneumonia — Duration

Due to Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Meuland Edward Day M.D.
Address 4-E-33rd St Balto K Date signed Aug. 12 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G42814 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN E. DEMPSTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret S. Dempster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1865

8. AGE: Years	Months	Days	If less than one day
81	6	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Lawyer
11. Industry or business

FATHER
12. Name George E. Dempster
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Ann Bull
15. Birthplace Harford Co., Md.

16 (a) Informant Mr. John S. Dempster
(b) Address 2831 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1946, at 9:30p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 18 1946 to Aug 9 1946 and that I last saw [illegible] alive on Aug 9 1946

Immediate cause of death: Coronary Artery Thrombosis — Duration 22d
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carroll Lovgard M. D.
Address Aug 10, 1946 2925 N. Charles St

Physicians: please write the causes of death clearly and legibly. It is especially important. correct age is especially important.

G42815 NEW

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G42815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH's HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3154 Rosemont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLYN MARIE SCHMIDT

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) 10 AUG 46

8. AGE: Years | Months | Days | If less than one day 7 hr. 30 min.

9. Birthplace BALTO MD. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Leonard Schmidt
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Leola Gosnell
15. Birthplace Balto Md

16 (a) Informant Mother
(b) Address 3154 Rosemont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 12 1946

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 AUG 1946 at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 AUG 1946 to 10 AUG 1946, and that I last saw HER alive on 10 AUG 1946

Immediate cause of death ATELECTASIS — Duration

Due to

Due to

Other Conditions PREMATURITY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry T. Wilson, Jr. M.D.
Address St. Joseph's Hosp Date signed 10 Aug 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G42816 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Chandler Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Zedie Nixon
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lois
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Kinston, N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Md. Drydock Co.

FATHER
12. Name James Nixon
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace N. C.

16 (a) Informant Lois Nixon
(b) Address 837 N. Fulton Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/12/46 (month) (day) (year)
(c) Cemetery or crematory
Location Kinston, N. C.

18 (a) Funeral director Joseph L. Locke
(b) Address 704 N. Central Ave

19 (a) AUG 12 1946 (Date rec'd by registrar) Huntington Williamsville, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Bacterial Endocarditis
Acute Dilatation of Heart
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mc Mechan M.D. Medical Examiner.
Date signed 8/9/46

VS 191

G42817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42817 Registered No. 1312

Please write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 N. Carlton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Carlton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Parran

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widow

6 (b) Name of husband or wife Maggie Parran
6 (c) If married, widowed, or divorced, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1883

8. AGE: Years	Months	Days	If less than one day
63	3	24	hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Richard Parran
13. Birthplace Calvert Co. Md.

MOTHER 14. Maiden Name Elizabeth
15. Birthplace Calvert Co. Md.

16 (a) Informant George Parran
(b) Address 619 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs. Katie K. Williams
(b) Address 2229 Eutaw Place
(c) Washington Williams, M.D. Registrar
AUG 14 1946 Date received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1946 at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946 to 8/9 1946 and that I last saw h alive on 8/9 1946.

Immediate cause of death

	Duration
Cardiac Renal	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Hatcher M. D.
Address 1711 Eutaw Pl Date signed 8-11-46

VS 150

G42818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

G42818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Winborn
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1901

8. AGE: Years	Months	Days	If less than one day
45	7	8	1 hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation H. Wife
11. Industry or business

FATHER 12. Name Albert Hammond
13. Birthplace md

MOTHER 14. Maiden Name Addie Brown
15. Birthplace md

16 (a) Informant Helen Holland
(b) Address 1519 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/46 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date received by registrar) (b) Registrar

AUG 12 1946
VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1946, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1946 to Aug 9 1946, and that I last saw h alive on Aug 9 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Pulmonary Emphysema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dr Pulmonary Emphysema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thurston Reese
Address Redwood + Greene Date signed 8/12/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G42819
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4705 Blue Ridge
(c) Hospital or institution: Home 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4705 Blue Ridge
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country U. S.

3 (a) FULL NAME ~~Philip~~ Filippo Azzara

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Salvatora Azzara

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.) June 27, 1882

8. AGE: Years 64 | Months 1 | Days 16 | If less than one day: hr. min.

9. Birthplace: Sicily, Italy
(Town, county, and state)

10. Usual Occupation: Owner of Liquor Store

11. Industry or business

FATHER
12. Name: Salvatore Azzara
13. Birthplace: Sicily, Italy

MOTHER
14. Maiden Name: Josephine Prince
15. Birthplace: Sicily, Italy

16 (a) Informant: Lucy Miraglia
(b) Address: 470 S Blue Ridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore, Md.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52 N. Morley St. Huntington Williams, M.D.
Registrar

19 AUG 12 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946, at 2:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to Aug 11 1946, and that I last saw him alive on Aug. 11 1946

Immediate cause of death: Carcinoma of Bladder — Duration: 10 Mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: Nov. 5, 1945
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: None
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Charles B MacMunn M. D.
Address: 2911 E. Baltimore St. Date signed: Aug 11 1946

G42820 BALTIMORE CITY HEALTH DEPARTMENT G42820 Registered No.

CERTIFICATE OF DEATH 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 N. Dallas
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 1945

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 N Dallas
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Junius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Anthoney Brown

13. Birthplace Va

MOTHER 14. Maiden Name Bettie Tucker

15. Birthplace

16 (a) Informant Junius Mason

(b) Address 615 N. Dallas

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 46 (month) (day) (year)

(c) Cemetery or crematory Emporia Cem

Location Emporia Va

18 (a) Funeral director Elroy D. Wilson

(b) Address 1000 ABG Dentley ave

19 (a) [illegible] (Date received by registrar) Huntington W. Gwathmey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1946 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1946 to Aug 9 1946, and that I last saw h[illegible] alive on 8-8 1946

Immediate cause of death Carcinoma of Colon — Duration

Due to Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Edward Fisher

Address 1623 Monument Date signed 8-9-46

Please answer all questions. Be sure that the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 250

G42821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

G42821
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Childrens Hospital School 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 M 11 d 4 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Caroline St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Graves

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 June 1933

8. AGE: Years	Months	Days	If less than one day
13	2	5	hr. min.

9. Birthplace Baltimore City, Md
(Town, county, and state)
10. Usual Occupation School Child
11. Industry or business None

FATHER
12. Name Lorenzo Graves
13. Birthplace Suffolk, Virginia

MOTHER
14. Maiden Name Florine Brown
15. Birthplace Suffolk, Virginia

16 (a) Informant Father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13 46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Brooklyn, Md
18 (a) Funeral director Elroy A. Wilson
(b) Address Bentley ave
AUG 12 1946
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 August 1946, at 10 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 26 June 1946, to 10 August 1946, and that I last saw him alive on 10 August 1946.

Immediate cause of death	Duration
TB Meningitis	1 mo
Due to TB of Thoracic Spine	17 mos
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William J. Wilson M. D.
Address Childrens Hospital School Date signed 10 Aug 46

VS 3

X

G42822
HB # 109822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G42822
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hour
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 546 48th St. Essex (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Bartling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry Bartling

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) May 5, 1894

8. AGE: Years 52 Months 3 Days 4 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John R. Wilson
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Krouse
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location German Hill Road

18 (a) Funeral director M. J. Sullivan & Sons
(b) Address 1808 Eastern Ave

19 (a) Date received AUG 12 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1946, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 9, 1946 to August 10 1946 and that I last saw him alive on Aug. 9 1946.

Immediate cause of death Cerebro-Vascular Accident — Hemorrhage — Duration

Due to Hypertensive C-V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto City Hosps Date signed 8-9-46

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important. Use no abbreviations or ditto marks. Be sure every question is answered.

G42823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G42823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Edmonson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Edmonson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANKLIN G. BAER

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-40-6324

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose M. Baer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1889

8. AGE: Years 57 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Interior Decorator

11. Industry or business McDonnell Co

FATHER 12. Name Peter Baer
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Mary Miller
15. Birthplace Md

16 (a) Informant Mrs. Rose M. Baer
(b) Address 3016 Edmondson ave

17 (a) Burial (b) Date thereof Aug. 13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Harry A. Kirkpatrick
(b) Address 4101 Edmondson ave

19 (a) AUG 12 1946 (b)
Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/46 19 , at 11:54 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 8/10/46

G42824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48B

G42824 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 S. Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 501 S. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie B Barfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widow

6 (b) Name of husband or wife Late George W Barfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1872

8. AGE: Years	Months	Days	If less than one day
74	3	10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name (Unknown) Lentz
13. Birthplace Germany
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant George W. Barfield
(b) Address 501 S. Fulton Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug. 13/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H Weyler
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 12 1946
Reg No 12 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1946, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 1945 to Aug 10 1946, and that I last saw her alive on Aug 9 1946.

Immediate cause of death Terminal Pneumonia — Duration Aug 7-10

Due to Generalized Carcinoma

Due to Carcinoma of Uterus

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: no
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence no at M
(c) Where did injury occur? no
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W Wallace Walker M.D.
Address 422 Med Art Bldg Date signed Aug 10 46

G42835 — BALTIMORE CITY HEALTH DEPARTMENT — 94 — G42835

CERTIFICATE OF DEATH

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Stamford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Stamford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Mills Tippett
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: J. Preston Tippett | 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 23, 1900
8. AGE: Years 45 | Months 9 | Days 17 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Harry H. Routson
13. Birthplace Md

MOTHER
14. Maiden Name Pearl Taylor
15. Birthplace Md

16 (a) Informant J. Preston Tippett
(b) Address 621 Stamford Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd
18 (a) Funeral director Harry H. Nitzke
(b) Address 401 E Edmondson ave
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1946 at 4:20 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1946 to 8-10 1946 and that I last saw her alive on 8-10 1946.

Immediate cause of death	Duration
Coronary Thrombosis,	death
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo. E. Wells M. D.
Address 4105 Edmondson Ave Date signed 8/10/46

VS 150

for Bill H. Kammer, by Howard J. Maldeis, M.D.

642826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 B

Registered 642826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) ~~No~~ Md. (b) County BALTIMORE.
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 46 N. Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY A HILL
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Fannie May Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1875

8. AGE: Years	Months	Days	If less than one day
70	9	3	hr. min.

9. Birthplace Balto. Md (Town, county and state)
10. Usual Occupation Retired messenger
11. Industry or business Railway Exp.

FATHER
12. Name John A. Hill
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine Love
15. Birthplace Va.

16 (a) Informant Mrs. Fannie May Hill
(b) Address 46 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Haven H. Wilhide
(b) Address 4101 E. Monument ave

19 (a) Harrington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1946 to Aug 10 1946 and that I last saw ~~him~~ her alive on 10 Aug 1946.

Immediate cause of death: Terminal Circulatory Collapse

Due to: Cardiac Failure Hodgkin's Disease

Due to: Prostate Fourth metastasis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L Byerly M.D.
Address University Hospital Date signed 8-10-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 46

G42827
AD 102622

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G42827
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 27yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gladstone

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-1468

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25- 1870 1880

8. AGE: Years	Months	Days	If less than one day
65	10	13	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Betsy ?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug 13-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Lutheran
Location West Port

18 (a) Funeral director Wm Brooks
(b) Address 1463 N Carey St

19 (a) (b)
(Date rec'd by registrar) Registrar

AUG 12 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8- 1946 at 2.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 1946 to 8-8 1946 and that I last saw him alive on 8-8 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days

Due to Hypertension, cardiac sclerosis — 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Rowell Huffington M.D.
Address Baltimore City Hosp. Date signed 8 Aug 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G42828 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 41
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Myrtle Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza DUNN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Abraham Olivia Dunn

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1901

8. AGE: Years 45 | Months 8 | Days 11 | If less than one day: hr. min.

9. Birthplace Kenston N. Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Cox
13. Birthplace Kenston N. Carolina

MOTHER
14. Maiden Name Susan Cox
15. Birthplace Kenston N. Carolina

16 (a) Informant Husband
(b) Address 318 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 158 AUG 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/46 1946 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19; that last saw him alive on 8/11/ 1946.

Immediate cause of death: Secondary anemia
Pulmonary tuberculosis — Duration 10-12 months
Due to: Carcinoma of Body of uterus
Due to: Pelvic infiltration and pleural pneumonitis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sandra Freeman M. D.
Address Provident Hosp Date signed 8-12-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193 D

Registered No. G42829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Patapsco St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert P. Harrison

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Mary A. Sass
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/1868

8. AGE: Years	Months	Days	If less than one day
77	9	23	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Health Dept. Clerk
11. Industry or business

FATHER
12. Name John O. Harrison
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Hurly
15. Birthplace Balto.

16 (a) Informant Family
(b) Address 1504 Patapsco St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 8/13/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director J. L. Tee Cauley
(b) Address 130 E. Fort Ave.

19 (a) AUG 12 1946 Registrar
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9. 1946 at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1946 to Aug 9 1946, and that I last saw him alive on Aug 9 1946

	Duration
Immediate cause of death: Coronary thrombosis	1 day
Due to Senile myocarditis	6 mos
Due to Arteriosclerosis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Harrison
Address 1 E. Preston St. Date signed 8/13/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G42830
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 664 Portland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Moore

6 (c) If alive, give address

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years: 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Lithuania
(Town, county, and state)

10. Usual Occupation: Grocer

11. Industry or business: self

FATHER
12. Name: Francisco Moore.
13. Birthplace: Lithuania

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Lithuania

16 (a) Informant: Leslie Moore
(b) Address: 64 Portland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Edgard Rd.

18 (a) Funeral director: Chas. H. Jackman
(b) Address: 703 N. Carey St.

Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1946, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-renal Disease

Due to

Other Conditions Hyfer tension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Maccani M.D.
Medical Examiner.
Date signed 8-10-46

HEALTH DEPARTMENT—CITY OF BALTIMORE

G42831 G42831

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 St. Mary's St. 7-1 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 63 yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Laura Sheppard

If U.S. Veteran specify WAR .....

(a) Residence: No. 528 St. Mary's St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem | 4. Color or Race: Col. | 5. Single, Married, Widowed, or Divorced (write the word): Widowed

3a. If married, widowed or divorced: HUSBAND of (or) WIFE of Louis Sheppard

6. DATE OF BIRTH (month, day, year): 1883

7. AGE: Years 63 | Months | Days — | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Dakota Md

FATHER

13. NAME: Wesley Creamer

14. BIRTHPLACE (city or town) (State or country): Md.

MOTHER

15. MAIDEN NAME: Sarah Talbot

16. BIRTHPLACE (city or town) (State or country): Ford

17. INFORMANT: Celivia Yancy Sister

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Date 8-14 19 46

19. UNDERTAKER: Mrs. Frances A. Hensley

(Address) 378 W. Biddle St

Huntington Williams, Mgr.

FILED AUG 12 1946

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Aug 9 19 46

22. I HEREBY CERTIFY, That I attended deceased from July 14 46 to Aug 8 19 46

last saw h.r alive on Aug 8 19 46 Death is said to have occurred on the date stated above at 10:10 A M.

The principal cause of death and related causes of importance were as follows:

Cerebral Haemorrhage

Date of onset

Other contributory causes of importance:

Was an operation performed? ..... Date of .....

For what disease or injury? .....

What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19...

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Frank E. Wagner M. D.

(Address) 3027 Calvert St

X

G42832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G42832
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 851 West Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Izo Schoffner (Shoffner)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mahala Shoffner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1894

8. AGE: Years 52 | Months 2 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Hollow Rock Tennessee
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henderson Shoffner
13. Birthplace Tennessee

MOTHER
14. Maiden Name Natalie Lyst
15. Birthplace Tennessee

16 (a) Informant Mahala Shoffner
(b) Address 851 W Fayette St

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** Aug. 13/46 (month) (day) (year)

(c) Cemetery or crematory
Location Hollow Rock Tennessee

18 (a) Funeral director Wm. Colt A. Elliott & Dgt
(b) Address 129 N. Carrollton St

AUG 12 1946

19 (a) (Date rec'd by registrar) **(b)** Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/46 19... at 1:44 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm C Davis M.D.
Medical Examiner.
Date signed 8/12/46

X

G42833 new

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157 E Reg. Dist. No.

G42833

PLACE OF DEATH:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Usual residence, institution, or street address where death occurred: 1026 Lemeston Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1026 Lemeston Ave. Baltimore Md
(If rural, give LOCATION)

2.(a) If veteran, name war

1. FULL NAME: Danny Eugene Marsh

3. (b) Social Security Number

3. Color or race	4. If single, married, widowed, or divorced
W	Single

Name of husband or wife

4.(a) If alive, give age ____ years

Date of death (mo., day, yr.): Aug. 11, 1946

AGE: Years | Months: | Days: 1 | If less than one day: ____ hrs. ____ min.

Birthplace: Baltimore Md
(Town, county, and state)

Usual occupation

Industry or business

72. Name: Harold Ora Marsh

73. Birthplace: New York

74. Maiden name: Dorothy May Wright

75. Birthplace: Carroll Co. Md

Informant: Dorothy May Wright Marsh

Address: 1026 Lemeston Ave Balto

Burial, cremation, or removal. Which? Burial Date thereof: 8-13-46 (month) (day) (year)

Cemetery or crematory: Taylorsville Cemetery

Location: Taylorsville Md

Funeral director: C. M. Mabe

Address: Mayfield Post Office Williamsport, Md.

AUG 13 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2, 1946 at 6 a. m.

21. I CERTIFY that death occurred on the date above stated: that I last attended deceased from Aug 11, 1946 to Aug 12, 1946 and that I last saw deceased alive on Aug 11, 1946

Immediate cause of death: Premature 5 mo., Pulmonary edema — DURATION

Due to: Congenital heart — condition

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

22. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Md Date signed: 8/12/46

G42834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G42834 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2341 W Lexington St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) — 20'
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 W Lexington St
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Mary Ellis Peters

3 (b) If veteran, name war: —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Otis F. Peters Sr
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 5 - 1890

8. AGE: Years	Months	Days	If less than one day
56	3	5	hr. ... min.

9. Birthplace Hagerstown Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Robert Ellis
13. Birthplace Md

MOTHER
14. Maiden Name Mary Sheckells
15. Birthplace Md

16 (a) Informant Mr. Otis Peters
(b) Address 2341 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo. E. Boyer Jr
(b) Address 1512 Hollins St

19 (a) ... (b) Huntington Williamsport, Md

AUG 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10- 1946, at 12 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1946 to 8-10- 1946, and that I last saw him alive on 8-10 1946.

Immediate cause of death: Coronary Thrombosis — Duration 3½ hrs.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy: None —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature W. B. Schreiber M.D.
Address 54 S Fulton Ave Date signed 8-12-46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

42835 new

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 159

G42835
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Aves.
(c) Hospital or institution:
Church Home Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs. 3 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs. 3 min.

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Dundalk 22
(d) Street No. 2903 Dunmore Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Farmer, Baby Boy
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8/11/46 - 257 AM

8. AGE: Years | Months | Days | If less than one day 2 hr. 3 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Quentin Farmer
13. Birthplace Middlesboro. - Tenn.

MOTHER
14. Maiden Name Louise Caudle
15. Birthplace So Carolina

16 (a) Informant Father.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address
Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/46 1946, at 5 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1946, to 8/11 1946, and that I last saw him alive on 8/11 1946.

Immediate cause of death Prematurity — Duration

Due to Miscarriage @ 6½ mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. J. Arnold M.D.
Address Church Home Hospital Date signed 8/11/46

3708 N. Broadway Baltimore 34, Md. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 186

2836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1936

Registered No. G42836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N Howard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jay Drew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 91946

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 13 1946 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 July 1946, at 7 00 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work
(d) Means of injury

23. Signature William G Helfrich M.D. Medical Examiner.

Date signed 1 Aug '46

a 49467 Allen

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 642837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N Exeter, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Garnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race black | 6 (a) Single, married, widowed, or divorced

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-46

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Kerby
13. Birthplace ? ? ?

MOTHER 14. Maiden Name Louise Garnes
15. Birthplace ? ? ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo AUG 71946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 13 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1946 at 12:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from August 2 1946 to August 2 1946 and that I last saw her alive on August 4 1946

Immediate cause of death: Hemorrhage Disease of Newborn

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M.D.

Address Date signed 8/5/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42838 G42838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Dover (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Laura Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-46

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Mattie Stewart
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo AUG 5 1946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 13 1946 (Signature) for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1946, at 1 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1946 to Aug 2 1946 and that I last saw h[illegible] alive on Aug. 2 1946.

Immediate cause of death Hemorrhagic Disease — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Faelden
Address Date signed 8/7/46

3709

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G42839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aaron C. Grammer

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ W

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1858

8. AGE: Years 88 | Months | Days 4 | If less than one day hr. min.

9. Birthplace Balto Co. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown Crommer

13. Birthplace Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace Md

16 (a) Informant Annie V. Staubitz

(b) Address 1206 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/46 (month) (day) (year)

(c) Cemetery or crematory Balto Cem.

Location Baltimore

18 (a) Funeral director William Cook. Inc

(b) Address 1217 St Paul St.

19 AUG 13 1946 (Registered number) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946 at 6 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 15 July 1946 to 11 Aug 1946.
and that I last saw h alive on 1946

Immediate cause of death Coronary thrombosis — Duration 3 weeks.

Due to Coronary disease and angina — Duration ?

Due to Arteriosclerosis

Other Conditions old age
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverfield M.D.

Address 714 E. Preston Date signed 12 Aug 46

X

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G428.0 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G428.0

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Streets
(c) Hospital or institution: Franklin Square Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Fernhill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gerard Hausmann

3 (b) If veteran, name war: Unknown
3 (c) Social Security Account No. Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida Hausmann
6 (c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) June 26, 1881

8. AGE: Years	Months	Days	If less than one day
65	1	17	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Auditor U. S. Government
11. Industry or business

FATHER
12. Name George Hausmann
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Moseley
15. Birthplace Baltimore, Md

16 (a) Informant Gerard Hausmann
(b) Address 3810 Fernhill Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1946, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 3 1946, to August 12 1946, and that I last saw h[im] alive on August 12 1946.

Immediate cause of death	Duration
Pleural Effusion	
Atelectasis-Pulmonary	
Due to Myocardial Infarction	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gerard Hausmann
Address Franklin Sq Hosp Date signed 8/13/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G128:1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43 D

Registered No. G128:1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4104 Moravia Ave
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 Moravia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frieda Haupt

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W. | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~. W

6 (b) Name of husband or wife Rudolph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26 1872

8. AGE: Years 74 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown Becker
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs Minnie Herbert
(b) Address 4104 Moravia Ave

17 (a) Burial (b) Date thereof 8/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville -

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 46 to Aug 8 1946 and that I last saw him alive on Aug 8 1946

Immediate cause of death: (a) Acute Cardiac failure — Duration

Due to (b) Arteriosclerotic Cardio-Vascular disease

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Stevens M.D.
Address 3400 Orleans Date signed 8/12/46

Instructions: Please answer all questions. Use ditto marks (") where appropriate. Do not use abbreviations except in addresses. Be sure that information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G428:2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 198

Registered No. G428:2

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 25
(e) Length of stay in Baltimore (yrs., mos., or days) 77

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Car. (b) County
(c) City or town West Spencer (If outside city or town limits, write RURAL and give town)
(d) Street No. 77 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd Walker (M.P. # 34322)

3 (b) If veteran, name war: Unknown
3 (c) Social Security Account No. 246-12-8968
4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 5, 1923
8. AGE: Years 23 | Months 7 | Days 4 | If less than one day hr. min.
9. Birthplace West Spencer, N. Car. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Walker
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Mary Douglas
15. Birthplace N. Carolina

16 (a) Informant
(b) Address Unk -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 13 46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Dorsey Hall Rd
18 (a) Funeral director J. Embry Hobbins
(b) Address 1316 Light St Huntington Williams, Mgr
19 (a) Registrar

AUG 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1946, at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1945, to Aug. 9 1946, and that I last saw h[illegible] alive on Aug 9 1946.

Immediate cause of death: Dislocation of 6th Cervical vertebra — Duration
Due to: Execution by hanging
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Ambrose, M. D.
Address Temple Court Apts. Date signed 8-9-46

2823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1612

Registered No. G42823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/9/46

8. AGE: Years | Months | Days | If less than one day: 12 hrs min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY AUG 9 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 AUG 13 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1946, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy + inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSTOM OF DEATH Atelectasis neonatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. Schmidt M.D.
Medical Examiner.
Date signed 8/9/46

VS 151

G42844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G42844 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 Auchentoroly Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Auchentoroly Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA R. KELLER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Howard L.B. Keller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 11, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
78	1	0		

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Gustave H. Ruppersberger
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret C. Ritter
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. J. Herman Neuman
(b) Address: 339 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14 1946 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem
Location: Pikesville Md.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North AmPennsylvania Aves

19 (a) Aug 13 1946 (b) Registered Aug 15 1946 Registrar for Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11th 1946, at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2nd 1946, to Aug 11 1946 and that I last saw h[illegible] alive on Aug. 10 1946.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to: Cerebral Hemorrhage — Left Hemiplegia

Due to: Arteriosclerotic vascular disease

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Howland Edward Day M. D.
Address: 4-E-33rd St Balto-18 Date signed Aug 14 1946

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G42845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 S. Stricker St.
(c) Hospital or institution:

19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME W. STANLEY SEATON

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1894

8. AGE: Years	Months	Days	If less than one day
51	10	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name William A. Seaton
13. Birthplace Minn.

MOTHER
14. Maiden Name Mary V. Donnelly
15. Birthplace Balto.

16 (a) Informant Mrs. Mary V. Seaton
(b) Address 33 S. Stricker St.

17 (a) Burial (b) Date thereof 8/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Thurlington Williams M.D.
(Date rec'd by registrar) Registrar

AUG 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11. 19 46. at 1:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946 to Aug 11 1946.
and that I last saw him alive on Aug 10 1946.

Immediate cause of death — Duration

starvation acidosis — 1 week

Due to Malignancy, recurrent right

Due to carcinoma region — 3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Nathan Raesun M. D.
Address 206 S. Gilmor St Date signed 8-12-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G428:6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 Registered No. G428:6

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 04
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Fait ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles A. Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Margaret Oliver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1871

8. AGE: Years 74 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Bertha Jones
(b) Address 2819 Fait ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave.

18 (a) Funeral director John J. Duda
(b) Address 2824 Hudson St.

19 (a) AUG 13 1946 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1946, at 6 45 A.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Russell M.D. Medical Examiner.
Date signed 8-12-46

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

93D

6428:7

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 9165 Robinwood St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... da.

2. FULL NAME John L. Belzner

If U. S. Veteran specify WAR .....

(a) Residence: No. 916 S. Johnson St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Belzner

6. DATE OF BIRTH (month, day, year) July 20 1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	-	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. lawyer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Boy Factory

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation 7

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME John L. Belzner

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Anna Koch

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mary E. Belzner
(Address) 916 S. Robinwood St

18. BURIAL, CREMATION, OR REMOVAL
Place Oak Lawn Cem. Date Aug 14 19 46

19. UNDERTAKER John J. Duda
(Address) 1629 Hudson St.

20. FILED ..... 19.... .....
Registrar.

AUG 13 1946 Huntington Williamsport, Md

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug. 11, 1946

22. I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1946 to Aug. 11, 1946

I last saw h.. alive on Aug. 11, 1946 Death is said to have occurred on the date stated above, at 12:25 P.m.

The principal cause of death and related causes of importance were as follows:

ARTERIOSCLEROSIS — Date of onset unknown.

Other contributory causes of importance:

MYOCARDITIS — 1 yr.

Was an operation performed? NO Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? NONE Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify .....

(Signed) J. Bingaman Bjelstein M. D.

(Address) 421 S. Highland Ave

X

C42848 Patrick

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1220

C42848 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 N. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Brusak

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11 1870

8. AGE: Years 75 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Salak
13. Birthplace Bohemia

MOTHER
14. Maiden Name Theresa Habat
15. Birthplace Bohemia

16 (a) Informant Mary Handler
(b) Address 910 N. Patterson Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Enoch Broadbent
(b) Address 700 N Gilmor
(c) Huntington Williams

AUG 13 1946 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1946 to Aug 11 1946 and that I last saw h[er] alive on Aug 11 1946

Immediate cause of death: Acute cardiac dilatation — 8/11/46
Due to Duodenal obstruction
Due to Strangulated hernia — 8/8/46
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William J Brauer
Address 801 N Kenwood Ave Date signed 8/12/46

X

VS 150

G42849 pwb

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5 6D

G42849 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Redwood & Green St.
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gross, Mary Ellen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/43

8. AGE: Years	Months	Days	If less than one day
2	5	18	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Beatrice Kays
15. Birthplace Md.

16 (a) Informant George Gross
(b) Address 634 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-46 (month) (day) (year)
(c) Cemetery or crematory Antietam
Location Balto. Co.

18 (a) Funeral director Frank W. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) (Date received by local registrar) (b) *Registrar

AUG 13 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1946 at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1946 to Aug. 12 1946 and that I last saw h.e.r alive on August 12 1946.

Immediate cause of death (a) Paralysis
(b) Meningitis

Due to

Due to

Other Conditions Supportive therapy and medication - left side

(Include pregnancy within 3 months of death)

Date of operation 8-3-46

Major findings of operation: Subarachnoid Cyst

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature X

Address University Hospital M. D.

Date signed 8-12-46

G42850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G42850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 E. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May A. Royer

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Harrison Royer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
about 45			hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. J. Bowie
(b) Address 1828 N. Caroline St.

17 (a) Burial (b) Date thereof 8/15/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Old U.S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (b) Huntington Williams Registrar

~~Date rec'd~~ AUG 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Aug 11 1946
and that I last saw her alive on Aug 11 1946.

Immediate cause of death	Duration
Coronary disease	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J. Singer
Address 506 E. North Ave Date signed 8/13/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G428[illegible]1 — 467 — (Registered No.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd
(c) Hospital or institution: 15

(d) Length of stay in ~~hospital or~~ inst. (yrs., mos., or days) 5 Weeks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winifred K. Owen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Hugh E. Owen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1866

8. AGE: Years	Months	Days	If less than one day: hr.	min.
79	9	0		

9. Birthplace Wales (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Isaac Owen
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Owen
15. Birthplace Wales

16 (a) Informant Evan D. Owen
(b) Address 1115 St. Paul St.

17 (a) Burial (Burial, ~~cremation, entombment~~) (b) Date thereof 8/14/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Granite
Location Md

18 (a) Funeral director William Cook Inc.
(b) Address 147 St. Paul St.

19 (a) AUG 13 1946 (Date rec'd by registrar) (b) Huntingtown Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1946 to 8/6 1946, and that I last saw her alive on 8/6 1946.

Immediate cause of death Cachexia — Duration

Due to abdominal malignancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Arthur W Kay M. D.
Address 3862 Dolfield Date signed 8/13/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X ave -15

G428:46 G428:52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46D

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 Wellesley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name town)
(d) Street No. 523 Wellesley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret Kelley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1876

8. AGE: Years 69 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William Kelley
13. Birthplace Baltimore

MOTHER 14. Maiden Name Julia Beck
15. Birthplace Baltimore Md

16 (a) Informant Margaret Kelley
(b) Address 523 Wellesley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore County
Location East End of Sta 56

18 (a) Funeral director William Boyle Jr
(b) Address 219 St Paul St

19 (a) (Date received by Registrar) AUG 13 1946 (b) Registrar's signature

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Aug 1946 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of rectum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelly M.D.
Medical Examiner.
Date signed 13 Aug 46

C42853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

C42853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Harlem Ave
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Harlem Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM A. ROBERTS

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-1884

8. AGE: Years	Months	Days	If less than one day
61	10	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Loan Office

FATHER
12. Name Henry Roberts
13. Birthplace Va.

MOTHER
14. Maiden Name Hester Roberts
15. Birthplace Va.

16 (a) Informant Elsie Roberts(Wife)
(b) Address 1510 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A County, Md.

18 (a) Funeral director Charles G.Cooper
(b) Address 510-512 N.Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 13 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9/1946 19 , at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1946 to Aug 9 1946 and that I last saw h alive on Aug 9, 1946

Immediate cause of death

(a) Hr. Val. Ht. D.

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bailey D. Twyford M. D.

Address 1522 Harlem Ave Date signed 8/12/46

Please write plainly in ink. Any error or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42854

G42854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 647 S. Streeper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 647 S. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta C. Seifert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	W

6 (b) Name of husband or wife John C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1859

8. AGE: Years	Months	Days	If less than one day
87	3	29	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Frederick Woolschleger
13. Birthplace Switzerland

MOTHER
14. Maiden Name Katherine Meister
15. Birthplace Germany

16 (a) Informant Mary E. Yingling
(b) Address 4731 Park Heights Ave.

17 (a) Burial (b) Date thereof 8/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) [illegible] Washington Williams, M.D.
(Date received) Registrar

AUG 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1946 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1946 to Aug 10 1946 and that I last saw h[illegible] alive on Aug 9 1946

Immediate cause of death

Cinchain of Lungs — Duration Years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.

Address 408 S. Patterson Pk. Date signed M.D. 8/12/46

G42855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46a

G42855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 946 S.Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 946 S.Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Diedeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1891

8. AGE: Years 54 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation house wife

11. Industry or business

FATHER
12. Name Henry Hohman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Hollerman
15. Birthplace St.Marys Co.Md.

16 (a) Informant George Diedeman
(b) Address 946 S.Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

19 (a) (Date rec'd by registrar) AUG 13 1946 (b) Huntington Ave. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Aug. 11 1946, and that I last saw him alive on Aug. 4 1946.

Immediate cause of death: Carcinoma of Ovarybags — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B. Hofe M. D.
Address 1331 Eutaw Date signed 8-12-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G42856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710

G42856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 E West Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma J. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Robert Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13 1864

8. AGE: Years	Months	Days	If less than one day
81	11	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Roberts
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Eliza Lezarr
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Amanda Voyce
(b) Address 119 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Fleury & Flannigan
(b) Address 1416 Light St.

19 (a) AUG 13 1946 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1946 at 10:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions Multiple fractures, lacerations, abrasions and bruised bruises (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-12-46 at 23/2 10:18 A.M.
(b) Where did injury occur? Light St., north of West St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Pedestrian struck by streetcar

23. Signature Thomas J. Claudius M.D. (Medical Examiner)
Date signed 8-12-46

VS 151

(2) G42857

BALTIMORE CITY HEALTH DEPARTMENT ✓ G42857

CERTIFICATE OF DEATH 112

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1421 Fulbert St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 26 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Fulbert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lindsay Philip Miller

3 (b) If veteran, name war None

3 (c) Social Security Account No. 208-07-7528

4. Sex male | 5. Color or race wh. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ruth B Miller

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Dec 22 1898

8. AGE: Years 48 | Months 7 | Days 21 | If less than one day hr. — min.

9. Birthplace West Bend Pa (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER 12. Name Charles L. Miller

13. Birthplace ?

MOTHER 14. Maiden Name Emma Aldridge

15. Birthplace ?

16 (a) Informant Ruth B Miller

(b) Address 1421 Fulbert St

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof AUG 13 1946 (month) (day) (year)

(c) Cemetery or crematory OAK GROVE

Location UNIONTOWN, PENNA.

18 (a) Funeral director WILLIAM COOK, INC

(b) Address 1417 Lexington St.

19 (a) (b) (Date rec'd by registrar) Registrar

AUG 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 : 13 1946, at 8 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1946 to 8 : 13 1946 and that I last saw him alive on 8 : 12 1946

Immediate cause of death: Status asthmaticus

Due to: asthma / Bronchial

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration
1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Summers M.D.

Address 1045 Belvedere Ave Date signed 8-13-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G42858

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 Harford Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward S. Krieger

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: ?
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 25, 1906
8. AGE: Years 40 Months 6 Days 14 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Jakob Krieger
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Nowak
15. Birthplace Md.

16 (a) Informant Mrs. Lena A. Krieger
(b) Address 1048 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd
18 (a) Funeral director Edgar W. Conklin Son
(b) Address 924 E. Eager St.
19 (a) (Date received by local registrar) (b) Registrar

AUG 13 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1946, at 3:40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug 12 1946 and that I last saw him alive on Aug 12 1946.
Immediate cause of death Shock

	Duration
Due to Acidosis	
Due to	
Other Conditions Malnutrition,	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James O'Hara, M.D.
Address Mercy Hosp. Date signed 8/13/46

G42859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G42859 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3123 Sequoia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Sequoia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLIS H. EHRLICH

3 (b) If veteran, name war -

3 (c) Social Security Account No. 216-05-0280

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Wennie Ehrlich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1883

8. AGE: Years	Months	Days	If less than one day
63	4	26 27	hr. min.

9. Birthplace Phila., Pa.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name David Ehrlich
13. Birthplace Germany

MOTHER
14. Maiden Name Jean
15. Birthplace Germany

16 (a) Informant Mr. David H. Ehrlich
(b) Address 3300 Mondawmin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 13 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1946 at 12:07 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1946 to Aug 11 1946.
and that I last saw h[illegible] alive on Aug 10 1946.

Immediate cause of death
Rectal Hemorrhage
Due to Hypertension C.V.D.
Due to
Other Conditions Carcinoma of Rectum
(Include pregnancy within 3 months of death)
Date of operation July 8 1946
Major findings of operation:
of autopsy:

Duration: 1 yr. 15 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. J. Hankins M.D.
Address 331 Cathedral St. Balto. Date signed 8/12/46

VS 150

PRINTING WRITE FIGURES, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2906426428 60 BALTIMORE CITY HEALTH DEPARTMENT ✓ G42860
CERTIFICATE OF DEATH 14 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~JOHNS HOPKINS HOSPITAL~~
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley W. Tutman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race black | 6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1926
8. AGE: Years 20 yrs | Months | Days | If less than one day hr. min.
9. Birthplace Md. (Town, county and state)
10. Usual Occupation Interior Decorator
11. Industry or business

FATHER
12. Name Robert Tutman
13. Birthplace Md.

MOTHER
14. Maiden Name Viola Campbell
15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/46 (month) (day) (year)
(c) Cemetery or crematory Gilbertus
Location Md
18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pressman St
19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

AUG 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1946 at 8:45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 8-2- 1946 to 8-10- 1946 and that I last saw h. alive on 8-10- 1946.
Immediate cause of death Tuberculosis Meningitis — Duration 3 weeks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work) (Specify type of place)
(e) Means of injury
23. Signature Douglas F. Bancel
Address Date signed 8 Aug. 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G42861 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Etting St
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Jn Davis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Widow

6 (b) Name of husband or wife Tilghman Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28th 1868

8. AGE: Years	Months	Days	If less than one day
78 77	-	16 15	12 hr. 50 min.

9. Birthplace Rosenth Balto Co Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Lizzie Johnson
15. Birthplace Md

16 (a) Informant Edward Davis
(b) Address 1022 E. Fmount st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14-1946 (month) (day) (year)
(c) Cemetery or crematory Antietam Cemetery
Location Hagerstown Md

18 (a) Funeral director George F. O. Gibson Sr
(b) Address 1735 Druid Hill Ave

Aug 13 1946 Huntington Williams, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12- 1946 at 125 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 11 1946 and that I last saw her alive on Aug 11, 1946

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 8-12-46

VS 150

certificate is especially important. Physicians: please write the cause of death clearly and legibly.

G42862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G42862 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Nettie H. Israel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1879

8. AGE: Years 66 | Months 11 | Days 24 | If less than one day: hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Clerk.

11. Industry or business U. S. P. O.

FATHER 12. Name Gilbert J. Israel
13. Birthplace Md

MOTHER 14. Maiden Name E. Virginia Keeton
15. Birthplace Md

16 (a) Informant Mrs. Morgan S. Cline
(b) Address Cockeysville apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15-1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Cockeysville Md

18 (a) Funeral director Geo. F. Bayard
(b) Address 1512 Hollins St.

19 (a) Date received by Local Registrar AUG 13 1946 (b) Huntington White, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th 1946, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1946, to Aug. 12 1946, and that I last saw her alive on Aug. 12 1946.

Immediate cause of death: Multiple pulmonary embolism - original thrombosis in left femoral vein — Duration

Due to

Due to

Other Conditions: Carcinoma of body of uterus
(Include pregnancy within 3 months of death)

Date of operation 8-6-46

Major findings of operation: Ca of body of uterus

of autopsy: Pulmonary embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Noguera MD
Address Maryland G. Hosp. Date signed 8/12/46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G42863

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Petersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Sycamore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-88

8. AGE: Years	Months	Days	If less than one day
57	8	22	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name John W. Hayes
13. Birthplace D.C.

MOTHER
14. Maiden Name Mary Eleigh
15. Birthplace D.C.

16 (a) Informant Personnel JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (b) Date thereof Aug 13, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Petersburg, Va.
Location

18 (a) Funeral director Wm. J. Ticknor & Sons
(b) Address North & Pa. Aves. Huntington Williamsburg, W. Va.

19 (a) 8-14-1946 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1946 at 2 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1946 to Aug 13 1946 and that I last saw him alive on Aug 13 1946.

Immediate cause of death Uremia

Due to

Due to

Other Conditions Rheumatic heart disease, chronic, with mitral & aortic stenosis & insuff.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Knight, Jr. M. D.
Address Date signed

X

51-30-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G42864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 EAST 30TH STREET
(c) Hospital or institution: NEITHER
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 EAST 30TH STREET
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ADELE FRANCES KENNEDY WISE

3 (b) If veteran, name war

3 (c) Social Security Account No. UNKNOWN

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife WILLIAM L WISE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 28, 1887

8. AGE: Years 58 59 | Months 10 | Days 17 | If less than one day 18 hr. 0 min.

9. Birthplace TROY RENASSLER NEW YORK
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name JOHN KENNEDY
13. Birthplace IRELAND

MOTHER
14. Maiden Name WINIFRED RYAN
15. Birthplace IRELAND

16 (a) Informant JOHN K WISE
(b) Address 2701 N. CHARLES ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-14-46 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREEN MOUNT AVE & 22ND ST.

19 (a) Date received by registrar AUG 14 1946 (b) Registrar Huntington Hillsdale, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18-1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Aug 11 1946, and that I last saw him alive on Aug 11 1946.

Immediate cause of death: Carcinomatosis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M.D.

Address 501 E North Ave Date signed 8/13/46

PRINTING WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

X✓ G42865

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster Route 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Warehime

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Denton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John Leffert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Scipp
15. Birthplace Germany

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/46 (month) (day) (year)
(c) Cemetery or crematory Riders Mem.
Location Westminster Md.

18 (a) Funeral director J. E. Myers Jr.
(b) Address Westminster Md.

19 (a) AUG 13 1946 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13-1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5-1946 to 8-13-1946 and that I last saw her alive on 8-13-1946

Immediate cause of death Post-operative shock

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-13-46

Major findings of operation: Extraovarian tumors; enlarged gall bladder

of autopsy: and fibroma

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Tuskey, M.D.

Address University Hosp. Date signed 8-14-46

VS 150

X

642866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G42866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly. N.A.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University of Maryland Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Heldan | Sheldon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Warrenton, Va. (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hospital Records
(b) Address Redwood & Greene

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

AUG 14 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12/46 19 . at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3/46 19 to 8/12/46 19 and that I last saw h[illegible] alive on 8/12/46 19

Immediate cause of death Cardiac failure — Duration

Due to Recent special infarct

Due to Cardiac dilatation & hypertrophy - hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Hypertrophied heart

of autopsy Recent infarct, dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Fraley, M. D.
Address Emergency Hospital Date signed 8/12/46

VS 150

G42867

AB-102942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G42867 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Teal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26-1909

8. AGE: Years	Months	Days	If less than one day
36	9	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Frank Teal (D
13. Birthplace ?

MOTHER — 14. Maiden Name Lottie Bailey
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director C. J. Halstead
(b) Address 918 Druid Hill Ave.

AUG 14 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946, at 8.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16- 1946 to 8-13 1946 and that I last saw h im alive on 8-13 1946.

Immediate cause of death Metastatic
Tumor of Brain — Duration

Due to Tumor of right lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Fowler
Address Balto City Hosps Date signed 8-13-46 M. D.

over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-[illegible]868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 513

G42868 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos. 4days 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 2
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3326 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 22-1873

8. AGE: Years	Months	Days	If less than one day
72	8	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard C. Thomas (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Richards (D
15. Birthplace [illegible]

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Filed AUG 14 1946 Registrar
(b) Registrar Huntington Hollowell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1946, at 4.27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1946, to 8-12 1946 and that I last saw him alive on 8-12 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr
Due to Cerebral Embolic	7 yrs.
Due to I can't diagnose	
Other Conditions Prostatic Enlargement (Include pregnancy within 3 months of death)	

Date of operation 8
Major findings of operation: 0
of autopsy: Carcinoma of Prostate

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas D Orwell M. D.
Address Balto. City Hosp. Date signed 7-15-46

X

G42869 4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G42869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 Savage St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Savage St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert E Clark.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-24-4249

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married.

6 (b) Name of ~~husband~~ or wife Anna C Weber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 - 1897

8. AGE: Years	Months	Days	If less than one day
48	9	19	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Ret. Policeman.
11. Industry or business

FATHER
12. Name Wm. H. Clark
13. Birthplace Balto.

MOTHER
14. Maiden Name Delia Bitner
15. Birthplace Balto.

16 (a) Informant Mrs. Anna C. Clark.
(b) Address 510 Savage St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery or crematory National Cem. Location Frederick Md.

18 (a) Funeral director John G Connelly.
(b) Address 718 Eastern Ave. Edward Huntington Williams, M.D.

19 (a) (Date received by local registrar) (b) AUG 14 1946 VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12, 1946 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Aug 12 1946.
and that I last saw h~~im~~ alive on Aug 12 1946.

Immediate cause of death: Coronary Thrombosis

Due to Embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
15 Minutes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm H. L. Sadler, M.D.
Address 3543 E. Baltimore St. Date signed 8-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G428.70

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G428.70 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Fait Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK ZIEGLER.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
76				

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER	12. Name William Ziegler.
	13. Birthplace Germany.
MOTHER	14. Maiden Name Elizabeth ?
	15. Birthplace Denmark.

16 (a) Informant Mrs. Wm Misc (Niece)
(b) Address 3501 FAIT AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/46 (month) (day) (year)
(c) Cemetery or crematory Tefft Alms House
Location Tefft, Md.

18 (a) Funeral director John P Connelly.
(b) Address 4180 Eastern Ave. Balto 24

19 (a) (Date rec'd by registrar) (b) Huntingtown Williamsport, Md.

VS 150 AUG 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Aug 1946, at 4.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5- 1946 to 8-10 1946 and that I last saw him alive on 8-10 1946.

Immediate cause of death Carcinoma of common duct with extension to liver & head of pancreas and metastasis to
Due to lungs -
Other Conditions

Duration Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James R. Cash M. D.
Address University Hosp Date signed 8-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G428:1 new

BALTIMORE CITY HEALTH DEPARTMENT ✓ G428:1
Registered No.

CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~[illegible]~~ Sinai Hosp.
(c) Hospital or institution: 6 Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs ✓
(e) Length of stay in Baltimore (yrs., mos., or days) ~~[illegible]~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5719 Narcissus Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Levy. Twin - D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1946

8. AGE: Years	Months	Days	If less than one day
NB.			3 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Levy
13. Birthplace New York.

MOTHER
14. Maiden Name Louise Schwartz
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Louise Levy
(b) Address 5719 Narcissus Ave.

17 (a) ..... (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 14 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1946, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1946, to Aug 10 1946 and that I last saw h... alive on ... 19..

Immediate cause of death

Prematurity

Due to (twin)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Seaman, M.D.
M. D.
Address Sinai Hosp. Date signed 8-13-46

X

128-72 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161A ✓

Registration No. G128-72

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6. Monument St.
(c) Hospital or institution: Sinai Hosp. ward
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. - 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Guilford Way (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1946

8. AGE: Years NB | Months | Days | If less than one day hr. 5 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Wentz
15. Birthplace Balto. Md.

16 (a) Informant Mary Smith
(b) Address 1208 Guilford Way

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 14 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1946 at 5:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1946, to July 11 1946, and that I last saw ... alive on ... 19...

Immediate cause of death — Duration

Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: atelectasis, ? Kolig ? pulmonary.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Neuman, M. D.
Address Sinai Hospital Date signed 7-17-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

G428.43 — Male — G428.43

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument & Broadway
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto-N
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5819 Narcissus Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Levy — Twin-A

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/46

8. AGE: Years	Months	Days	If less than one day
0			19 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Levy
13. Birthplace New York

MOTHER
14. Maiden Name Louise Schwartz
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Louise Levy
(b) Address 5819 Narcissus Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1946, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to Aug 11, 1946, and that I last saw h alive on Aug 11,

Immediate cause of death	Duration
Prematurity (Twin)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Kaufman, M.D.
Address Sinai Hosp. Date signed 8-12-46

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42874 | BALTIMORE CITY HEALTH DEPARTMENT | G42874

CERTIFICATE OF DEATH 930

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1222 Bayard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No 1222 Bayard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Kane
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1871

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business none

FATHER
12. Name Stephen Kane
13. Birthplace md

MOTHER
14. Maiden Name Martha Johns
15. Birthplace md

16 (a) Informant Sarah Parker
(b) Address 1222 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18 46
(month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 1142 Wolfe St

19 (a) (Date received by registrar) AUG 14 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1946, at 6.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1946, to Aug 13 1946, and that I last saw h[illegible] alive on Aug 13 1946.

Immediate cause of death: Uremia — Duration: 3 days

Due to: Prostatic Obstruction — 6 mos.

Due to:

Other Conditions: Hypertensive Cardio Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Urbach Jr M.D.
Address 1221 Wade Blvd Date signed Aug 14 1946

137A

G42875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G42875 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Fairfield
(b) Street address 3215 Tate St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Y
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Tate Fairfield
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Vanlandingham

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Benj. Vincent
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace S. C.

16 (a) Informant Beatrice Smith
(b) Address 3215 Tate St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Stamps
(b) Address 142 W Pratt St

19 (a) AUG 14 1946 (b) Huntington Williams
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1946, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1946 to 8/13 1946
and that I last saw him alive on 8/13 1946

Immediate cause of death
Ch. Nephritis
Due to Uremia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Rosetta M. D.
Address 2139 Druid Hill Ave Date signed

G42876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48A

Registered No. G42876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 S Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 S Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary V. McDonough

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name John McDonough
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Fahey
15. Birthplace Baltimore Md

16 (a) Informant Francis X. McDonough
(b) Address 1107 S Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Moran
(b) Address 3600 E Baltimore St

19 (a) AUG 14 1946 (Date filed by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946, at 11:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Aug 12 1946, and that I last saw h[illegible] alive on Aug 11 1946.

Immediate cause of death: Cancer of cervix — Duration: months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Novak M D

Address 408 S. Patt. Pl. Ave. Date signed 8/13/46

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G42877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

Registered No. G42877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 Carswell Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Carswell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE AGNES ULLRICH

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife Richard E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 11, 187[illegible]

8. AGE: Years	Months	Days	If less than one day
69	6	0	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Dressmaker
11. Industry or business Harris Dress Co.

FATHER
12. Name Karl Albrecht
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Burmeister
15. Birthplace Germany

16 (a) Informant Marie M. Ullrich
(b) Address 1624 Carswell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue, Parkville

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 S. t. Paul Street

19 (c) 8-14-1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13-August 1946, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20-Feb 1946 to 13-Aug 1946 and that I last saw h[illegible] alive on 13-Aug 1946

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Arteriosclerotic Cardio Vascular Disease — Feb-46

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation [illegible]
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Charles W. Edmunds M. D.
Address 1716 The Alameda Date signed 13-Aug-46

G428'78

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G428'78

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 W. Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter, Louis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name John
13. Birthplace Greece

MOTHER
14. Maiden Name Helen
15. Birthplace Greece

16 (a) Informant Wife JOHNS HOPKINS HOSPITAL Kent
(b) Address 4 Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-46 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Zamboros
(b) Address 433-440 E. North Ave

(a) AUG 14 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1946 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug 12 1946 and that I last saw h[illegible] alive on Aug 12 1946

Immediate cause of death Cardiac decompensation — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Wagley M. D.
Address Johns Hopkins Hosp. Date signed 8-12-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G42879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ASBURY SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	colored	Married

6 (b) Name of husband or wife Susie Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1901

8. AGE: Years	Months	Days	If less than one day
44	8	19	hr. min.

9. Birthplace Providence R.I.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Smith
13. Birthplace West Chester Pa.

MOTHER
14. Maiden Name Alice Parker
15. Birthplace Annapolis Md

16 (a) Informant Percy Smith
(b) Address 902 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15 1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Gilliam
(b) Address 922 N. Schroeder St.

19 AUG 14 1945 (Date rec'd by registrar) (b) Huntington Williamsport Pa.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1946, at 8:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of 6th Cervical Vertebra and injury to spinal cord

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-46 at 7:30 A.M.
(b) Where did injury occur? In front of 902 Harlem Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) NO
(d) Means of injury Fell down steps

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 8-12-46

VS 151

G42880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G42880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Garrison
(If outside city or town limits, write RURAL and give town)
(d) Street No. Stanton & Garrison Rds.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noah C. Stamer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary C. Stamer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 75 | Months | Days | If less than one day: hr. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation: Garage & Grocery

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Rose M. Marzullo.
(b) Address: Cockeysville. Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 14-46 (month) (day) (year)

(c) Cemetery or crematory: St. Charles
Location: Pikesville. Maryland

18 (a) Funeral director: Frank H. Wenzel
(b) Address: Pikesville. Maryland

19 (a) AUG 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1946, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Broken neck fractured and severed cervical vertebrae, ruptured diaphragm, fractured pelvis

Other Conditions: Multiple fractures of leg bones, fractured ribs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/11/46 at 7:15 P. M.
(b) Where did injury occur? Garrison, Balto. Co, Md
(c) Did injury occur at home or on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto.

23. Signature: Howard J. Mendenis M.D.
Medical Examiner.
Date signed 8-12-46

X

VS 151

Please write the causes of death clearly and legibly.

G42831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G42831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulkeens r Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 Annabel Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Emil Schaumann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-46

8. AGE: Years	Months	Days	If less than one day
		1	9 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER	12. Name George Schaumann
	13. Birthplace
MOTHER	14. Maiden Name Emma Agatha Dulaney
	15. Birthplace Baltimore Md

16 (a) Informant George Schaumann
(b) Address 2540 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine County
Location Woodlawn Md

18 (a) Funeral director Williams Corp Inc
(b) Address 217 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 120 AUG 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1946 to 8-12 1946 and that I last saw h[illegible] alive on 8-12 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hamilton Smith Jamison M.D.
Address St. Agnes Hosp. Date signed 8/14/46

X

G42882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G42882

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Kenyon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Kenyon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GERTRUDE HILL KEITH

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	216-09-6484	Female	White	Widow

6 (b) Name of husband or wife James E. Keith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1874

8. AGE: Years	Months	Days	If less than one day
72	1	3	hr. min.

9. Birthplace Harrisonburg, Va. (Town, county, and state)
10. Usual Occupation Saleswoman
11. Industry or business Comprecht & Benesch

FATHER
12. Name Charles Harper
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Shaneberger
15. Birthplace Md.

16 (a) Informant Mrs. Thomas J. Carroll
(b) Address 3305 Kenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 14 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1946, at 1:45a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Aug 1946 to 13 Aug 1946, and that I last saw h Sr. alive on 12 Aug 1946.

Immediate cause of death: Primary Carcinoma of Liver — Duration: 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Primary Carcinoma, Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Loy M Zimmerman
Address 2850 Kloman Rd Date signed 14 Aug 46

VS 150

G 2883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G42883

Please write the causes of death clearly and legibly. Physicians: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 West North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 West North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DONNA OLIVE WAITE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-07-0930

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank D. Waite

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1872

8. AGE: Years: 74 | Months: 2 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Townshend, Vt.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: William Gale
13. Birthplace: Vt.

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mr. Frank D. Waite
(b) Address: 3012 W. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory
Location: Wardsboro, Vt.

18 (a) Funeral director: WM. J. TICHNER & SONS
(b) Address: Balto., Md.

AUG 14 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13/46, 19, at 4 sup't M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/13/46

X

G42884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131Q

Registered No. G42884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 S. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STANISLAWA ZJADEWICZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Wladyslaw Zjadewicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name John Brzezinski
	13. Birthplace Poland
MOTHER	14. Maiden Name unknown
	15. Birthplace Poland

16 (a) Informant Joseph Zjadewicz
(b) Address 830 S. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 461 S. Chester Street

19 (a) AUG 1 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION 930

20. DATE OF DEATH Aug 12 1946 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1945 to Aug 12 1946 and that I last saw h[er] alive on Aug 12 1946

Immediate cause of death HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE — Duration 2/22/45

Due to

Due to

Other Conditions CEREBRAL HEMORRHAGE 2/22/45

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Zjadewicz
Address 209 S. Chester St Date signed 8/13/46

VS 150

X

G42885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G42885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 919 N. Gilmor St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jamie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1875

8. AGE: Years 70 | Months 9 | Days 16 | If less than one day: hr. min.

9. Birthplace Blackstone, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace Blackstone, Va

MOTHER
14. Maiden Name Elizabeth Jones
15. Birthplace Meckleneburg Co. Va

16 (a) Informant Mrs. Sally Jolly
(b) Address 919 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1601 Druid Hill Ave.

19 (a) Date rec'd by Reg. (Mar.) AUG 14 1946 (b) Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/46, at 2 45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 19 46 to 8/10 1946
and that I last saw her alive on 8/10/46

Immediate cause of death	Duration
(a) Intestinal Obstruction	
Due to (b) Mechanical Adhesions	
Other Conditions	

(Include pregnancy within 3 mos. of death)

Date of operation 8/10/46

Major findings of operation Mechanical Intestinal Obstruction (Adhesions)

Date of autopsy No Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Wiltcomb M. D.

Address 113 Harlem Ave. Date signed 8/13/46

G42886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G42886 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 W Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give county)
(d) Street No. 925 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Crossie Florence Baker
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Richard
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1889
8. AGE: Years 57 Months Days If less than one day hr. min.
9. Birthplace Maryland (City, county, and state)
10. Usual Occupation D
11. Industry or business

FATHER
12. Name Solomon Barney
13. Birthplace Md

MOTHER
14. Maiden Name Harriett Wallace
15. Birthplace 925 Mulberry

16 (a) Informant Richard Baker
(b) Address 925 Mulberry St
17 (a) Burial (burial, cremation, or removal) (b) Date thereof Aug 14 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto Md
18 (a) Funeral director Sarah A Brown Sons
(b) Address 1086 Mary Emery St

AUG 14 1946 (Date rec'd by Registrar) Hunter for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Aug 1946, at 4 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardio Vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Klyce M.D.
Medical Examiner.
Date signed 10 Aug 46

PG 12887

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

14

Registered No. 12887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run.
(c) Hospital or institution Lyndenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Homer St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Lillie Mae Howell (Howell)

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	S

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1934

8. AGE: Years	Months	Days	If less than one day
11	10	11	hr. min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business —

FATHER
12. Name Moses Howell
13. Birthplace Speed. N.C.

MOTHER
14. Maiden Name Estella Brown
15. Birthplace Speed. N.C.

16 (a) Informant parents
(b) Address 634 Homer St. Balto, Md.

17 (a) Burial (b) Date thereof Aug 15-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location A A Co Md

18 (a) Funeral director Isaiah L Bramble
(b) Address 10 E W Montgomery St.

19 (a) AUG 14 1946 Huntington Williams M.D.
(Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1946, at 9:24 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1946, to Aug 10 1946, and that I last saw her alive on Aug 10 1946

Immediate cause of death
Suspected tuberculous meningitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron G. Lee, M.D.

Address Lyndenham Hosp Date signed 8-10-46

VS 150

G42888 337003

BALTIMORE CITY HEALTH DEPARTMENT X V G42888
CERTIFICATE OF DEATH 92a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town Dundalk, (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 22 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Miller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race black | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Mamie Miller
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Cato Miller
13. Birthplace S. C.

MOTHER
14. Maiden Name Martha
15. Birthplace N.C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 14 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Mt. Calvary.
Location Balto. Md.

18 (a) Funeral director Walter B. Sorrell
(b) Address 139 Wilkens Street
(Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9/46 19 , to 8/11 1946, and that I last saw him alive on 8/11 1946.

Immediate cause of death Uremia Nephritis — Duration 1 hour

Due to Arterio Sclerosis — 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas S. Laurie M.D.
Address Date signed Aug. 12 '46

VS 150

PRINT WITH PENCIL, WRITE UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 ✓

G42839 Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 N. Broadway
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hanzlik

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-8567

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary (nee Michael)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/1893

8. AGE: Years	Months	Days	If less than one day
53 yrs.	3	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Lloyd Mitchell Co.,

FATHER
12. Name Anthony Hanzlik
13. Birthplace Austria

MOTHER
14. Maiden Name Katherine Josepheck
15. Birthplace Baltimore, Md.

16 (a) Informant Charles J. Hanzlik - brother
(b) Address 829 Brinkwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Rose St. & North Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

AUG 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 August 1946 at 10:40 P.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner

Date signed 11 August 1946

×

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42890 ✓ G42890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 542 N. Lakewood Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME August Klecka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lillian (nee Lottes)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1878

8. AGE: Years	Months	Days	If less than one day
68 yrs.	6	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation U. S. Marshal
11. Industry or business

FATHER
12. Name Joseph Klecka
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Hrdlicka
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Lillian Lottes Klecka
(b) Address 542 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Horner's Lane. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 260-05 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946 at 6 22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1946 to Aug 12 1946, and that I last saw h alive on Aug 12 1946.

Immediate cause of death Respiratory failure — Duration

Due to Bronchogenic carcinoma of left lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Barr M. D.
Address 6 W Lanvale St. Date signed 8/14/46

G42891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G42891 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Riviera Apts.
(b) Street address 901 Lake Drive
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. MANSBACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bessie F. Mansbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1871

8. AGE: Years	Months	Days	If less than one day
74	9 10	26	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Harry H. Mansbach,
13. Birthplace Germany.

MOTHER
14. Maiden Name ? Hirsch.
15. Birthplace Germany.

16 (a) Informant Mrs. A. Himmelrich,
(b) Address Dumbarton, Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/ 15/ 46.
(month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director
(b) Address 1902 Eutaw Place.

19 AUG 14 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13th. 1946 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9th 46 to Aug 13 1946.
and that I last saw him alive on Aug 13 46
Immediate cause
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
30 days
10 yrs
40 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Emersonian Apts. Date signed

Huntington Williamsport, Md

G42892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G42892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd.
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 7+ years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary J. Parlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-8-72

8. AGE: Years	Months	Days	If less than one day
74	5	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Dawson
13. Birthplace Donegal, Ireland

MOTHER
14. Maiden Name Mary Crowe
15. Birthplace County Clare, Ireland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16. 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Eager St

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1946 at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1941, to August 12, 1946, and that I last saw her alive on August 12, 1946.

Immediate cause of death: Cardiovascular Collapse — Duration: 1 day

Due to .....

Due to .....

Other Conditions Psychosis with Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond D. Mays M. D.
Address 336 Mulberry St. Date signed

G42893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G42893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 S Regester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 S Regester St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
63 62			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name	George Bradshaw
13. Birthplace	Va
MOTHER 14. Maiden Name	? Cunningham
15. Birthplace	Va.

16 (a) Informant Frederick A Davis
(b) Address 1319 Haley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Martin W.C. Diffel's Sons
(b) Address Lombard & Linn Sts

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 14 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 12 1946
and that I last saw h[illegible] alive on Aug. 12 1946.

Immediate cause of death Uraemia

Due to Kidney Calculus

Due to Hypertension & Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 36 hrs. ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] (Date signed) 8/13/46

X

Items 1-15, 17-19, and 22 must be filled in by the undertaker; items 16 and 20-21 by the physician; and item 23 by the physician or coroner. The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G42894 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 S. Ellwood ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 S. Ellwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas A. Pompei

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ married

6 (b) Name of husband or wife Margaret Trozzo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1923

8. AGE: Years 22 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Time Keeper

11. Industry or business Sparrows Point

FATHER
12. Name Attilio Pompei
13. Birthplace Italy

MOTHER
14. Maiden Name Alvira Pece
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 509 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16, 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 218 E. Baltimore st

19 (a) Date received AUG 14 1946 by Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946, at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 27 1946 to Aug 12 1946 and that I last saw h[illegible] alive on Aug 12 1946.

Immediate cause of death
Miliary Tuberculosis acute, general — Duration 3 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles V. Sarafi M. D.
Address 4220 Parkwood Ave Date signed 8/13/46

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC# 052734

BALTIMORE CITY HEALTH DEPARTMENT ✓ G12895
CERTIFICATE OF DEATH 104a
Registered No.

G12895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial ??
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Pentwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paula Jean Loebel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1946

8. AGE: Years — | Months — | Days 21⅝ | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry A. Loebel
13. Birthplace Milwaukee, Wis.

MOTHER 14. Maiden Name Virginia Starke
15. Birthplace Milwaukee, Wis.

16 (a) Informant Harry A. Loebel
(b) Address 1305 Pentwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 10 AUG 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-1946 at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper Respiratory Infection

Due to

Other Conditions Acute Congestion of Lungs
No Other.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen Medical Examiner. M.D.
Date signed 8/14/46

Please write the causes of death clearly and legibly. Physicians: please write a specific, not general, diagnosis.

G42896 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G42896

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5806 N. Ogsby Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Ogsby

3 (a) FULL NAME Shirley May Bryant.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-28-43

8. AGE: Years	Months	Days	If less than one day
3	3	16	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James E. Bryant
13. Birthplace

MOTHER
14. Maiden Name Ruth E.
15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) Burial (b) Date thereof 8-15-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Hollyfield
(b) Address 218 Edmondson Ave.

AUG 14 1946 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1946 at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1946 to Aug. 14 1946 and that I last saw h.[illegible] alive on Aug. 14 1946.

Immediate cause of death: Respiratory failure — Duration

Due to: Tuberculosis generalized — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alma J. Sheldon
Address Date signed 8/14/46

X

G42897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94Q

Registered No. G42897.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5712 Winner Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Winner Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Alden

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Charles Frank Alden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1890

8. AGE: Years	Months	Days	If less than one day
55	8	7	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county and state)
10. Usual Occupation Practical Nurse
11. Industry or business

FATHER
12. Name Martin L. Wiedeman
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan A. Mullinix
15. Birthplace Maryland

16 (a) Informant Franklin Charles Alden
(b) Address 3505 Cavendale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Byrne Funeral Home
(b) Address 3631 Falls Rd.

19 (a) AUG 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946 at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug 12 1946 and that I last saw him alive on Aug 12 1946

Immediate cause of death

	Duration
Coronary Thrombosis	12 hours
Due to Art. Sclerosis	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Miller M.D.
Address Pikesville-8, Md. Date signed 8/19/46

VS 150

G42898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G42898 ✓ 195E Registered No. G42898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 004
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Raspeburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 4908 Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald A. Schafer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12th 1938

8. AGE: Years	Months	Days	If less than one day
8	4	1	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation School child
11. Industry or business

FATHER
12. Name George F. Schafer
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Lillian V. Mehner
15. Birthplace Balto. Md.

16 (a) Informant Geo. F. Schafer
(b) Address 4908 Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 17 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co. Md

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Rd.

19 (a) AUG 14 1946 (Date received by registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1946 at 8 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH Shock -
Dislocation 2nd cervical vertebra with pressure on spinal cord
Due to Acute dilatation of heart
Edema + congestion of lungs
Other Conditions Acute congestion of all viscera
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/13/46 at Evening 7 P. M.
(b) Where did injury occur? Raspeburg, Md. (Public Carnival)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury From beam fell on him.

23. Signature Howard L. Malloy M.D.
Medical Examiner.
Date signed 8-14-46

VS 191

Please write the causes of death clearly and legibly. Physicians: please write as is especially important.

G42899 Amended

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42899 Registered No. 157M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Holman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/13/46

8. AGE: Years | Months | Days | If less than one day: 1/2 hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leslie Holman
13. Birthplace Balto.

MOTHER
14. Maiden Name Virginia Holman
15. Birthplace Balto.

16 (a) Informant Leslie Holman
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem.
Location Sykesville, Md.
18 (a) Funeral director C. Harry Derr
(b) Address Sykesville, Md.

19 (a) (Date received) (b) Registrar
AUG 14 1946 Registrar for Millersville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1946, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 19 46 to 8/13 19 46.
and that I last saw him alive on 8/13 19 46

Immediate cause of death: Cardio-Respiratory Failure
Duration:
Due to: Multiple Congenital Anomalies
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
Autopsy: Autopsy Findings Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hamilton Smith Jr. M.D.
Address St. Agnes Hosp. Date signed 8/14/46

G12500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G12500 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315 Taplow Road
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Taplow Road (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) **FULL NAME** REZIN HAMMOND Hodges

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 215-10-0317

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace S. Hodges

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Oct. 20 - 1890

8. AGE: Years 55 | Months 9 | Days 23 | If less than one day: hr. min

9. Birthplace Glen Burnie - A. A. Co., Md. (Town, county, and state)

10. Usual Occupation Sales manager

11. Industry or business Revere Copper & Brass

FATHER
12. Name Charles H. Hodges
13. Birthplace A. A. Co. - md.

MOTHER
14. Maiden Name Gertrude V. Benson
15. Birthplace A. A. Co. - md.

16 (a) Informant Mrs. Grace S. Hodges (wife)
(b) Address 315 Taplow Rd. - City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, md

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 W. North Ave. - City

19 (a) (Date received by registrar) AUG 1 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1945 to 8-12 1946, and that I last saw h[illegible] alive on 8-12 1946

Immediate cause of death: Bronchogenic Carcinoma — Duration 1 yr 7 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-10-46

Major findings of operation: Anaplastic Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Nelson Culey

Address 1014 St Paul St Date signed 8-14-46

G42901 A 49464 ALL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G42901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Laurette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrea Lehneebeli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-22-46

8. AGE: Years	Months	Days	If less than one day
		10 hr. 20	min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrea E. Lehneebeli -
13. Birthplace Penn.

MOTHER 14. Maiden Name Virginia Wilson
15. Birthplace Va

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 15 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1946 at 4 P 60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1946 to Aug. 11 1946 and that I last saw h[illegible] alive on Aug 11 1946

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Sheldon M.D.
Address Date signed 8/12/46

VS 150

G42903

A-9603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G42903
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town A.A.Co. -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Hartford Rd -
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Clark -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9, 46

8. AGE: Years	Months	Days	If less than one day
			18 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name Alma Clark
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 14 1946

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 15 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1946 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1946 to Aug 10 1946 and that I last saw he alive on Aug 10 1946

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred J. Sheldon M.D.

Address Date signed 8/10/46

VS 150

G42903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G42903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. Baltimore
(c) City or town ~~Roy Mattaux~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 837 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Ray Flemmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/7/46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Charles F Flemmer
13. Birthplace Va.

MOTHER — 14. Maiden Name Lottie Flemmer
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 15 1946 (Date filed by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8·10 1946 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8·6 1946 to 8·10 1946 and that I last saw h[illegible] alive on 8·10 1946

Immediate cause of death — Duration

Due to Prematurity

Due to Ruptured interval hem 2d trimester due to postnatal hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M.D.
Address Date signed 8-10-46

VS 150

G42904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

498325. 159 G42904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Mary Taylor.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4. 46

8. AGE: Years | Months | Days: 6. | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Roy Thomas

13. Birthplace Va.

MOTHER 14. Maiden Name Annie Briggs

15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address Dundalk

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School AUG 14 1946

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 15 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1946 at 1.49 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8. 1946 to Aug. 10 1946 and that I last saw him alive on Aug. 10 1946.

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred J. Sheldon M. D.

Address Date signed 8/10/46

X

G42905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. G42905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 S. Payson St
(c) Hospital or institution — 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia C. Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17 1883

8. AGE: Years 63 Months 4 Days 26 If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER
12. Name John Woods
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Dyer
15. Birthplace Ireland

16 (a) Informant Mr John Ryan
(b) Address 642 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901 S. Fulton Ave

19 (a) AUG 15 1946 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946 at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1945 to 8/12 1946
and that I last saw alive on 19

Immediate cause of death: Acute Pulmonary Edema
Malignancy of Lung 3 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration: 6 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Thomas V. O'Donovan M. D.
Address 1944 W. 3rd St Date signed

Shanahan

G42906 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G42906

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Brentwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mayhew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-46.

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James R. Mayhew
13. Birthplace Va

MOTHER
14. Maiden Name Helen J. Little
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Parkway Md

18 (a) Funeral director Wiseman Book Co
(b) Address 1217 St Paul Street

19 (Signature) AUG 15 1946 Huntington Williams, M.D. (Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1946 at 6 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946 to Aug 13 1946 and that I last saw him alive on Aug. 13 1946.

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Sheldon
Address Date signed 8/13/46 M.D.

VS 150

G42907 sued

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

G42907 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 S. Talbot St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country Poland

3 (a) FULL NAME Martha Jane Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1946

8. AGE: Years | Months | Days 16 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Russell Conner
13. Birthplace Md.

MOTHER: 14. Maiden Name Jane Rader
15. Birthplace Md.

16 (a) Informant Russell Conner
(b) Address 623 S. Talbot St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville Md.

18 (a) Funeral director Wm. Cook Inc
(b) Address 1317 St Paul St

AUG 15 1946 (Date received) (b) Registrar Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug. 1946; at 5:5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Aug 1946 to 14 Aug 1946, and that I last saw h[illegible] alive on 14 Aug 1946.

Immediate cause of death Acidosis — Duration

Due to Dehydration & Acidosis

Due to Pneumonia, Lobar

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pneumonia, Lobar

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8-18-46

VS 150

G42908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G42908 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important. Use only permanent supplies. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 St Paul St
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~ City Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 St Paul st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas LeMar Bower

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Male	White	Divorced

6 (b) Name of ~~husband or wife~~ Catherine Bauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23rd 1891

8. AGE: Years	Months	Days	If less than one day
55	2	21	hr. min.

9. Birthplace Hagerstown Md.
(Town, county, and state)

10. Usual Occupation Detective

11. Industry or business May Co.

FATHER
12. Name John Scott Bower
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden Name Blanche La Mar
15. Birthplace Balto. Md.

16 (a) Informant Blanche Bower
(b) Address 1212 St. Paul St.

17 (a) Burial (b) Date thereof 8/7/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1219 St Paul Street

19 (a) (b) ~~Huntington Hill~~ Registrar, M.H.
(Date rec'd by registrar)

AUG 10 1946

VS-181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14th 1946 at 8:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection / Inquiry thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema
Chronic Hypertrophic Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 8 14 46

G42909 (New)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G42909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga + Hudeland
(c) Hospital or institution: East Balt. more Gen Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Warren Smith Jr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/46

8. AGE: Years	Months	Days	If less than one day
		24	hr. min.

9. Birthplace Balt, mde, Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Warren N. Smith
13. Birthplace

MOTHER
14. Maiden Name Wanada Williams
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Warren N. Smith
(b) Address 2927 Windsor Ave

17 (a) — (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory City Burial
Location

18 (a) Funeral director
(b) Address

University Medical School AUG 14 1946
Commissioner of Health
AUG 15 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 August 1946, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Aug 1946 to 3 Aug 1946 and that I last saw h/ alive on 3 Aug 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Aspiration Pneumonia	
Due to	
Other Conditions Diarrhea — etc. unknown. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester A. Hall Jr. M. D.
Address Balt + Bellevue Date signed 8/3/46

VS 150

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42910 — BALTIMORE CITY HEALTH DEPARTMENT — 937 — G42910 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 63 E. Randall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 63 E. Randall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA M. SCHERER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife August F. Scherer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1873

8. AGE: Years	Months	Days	If less than one day
73	4	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Grishaber
13. Birthplace -

MOTHER
14. Maiden Name Sabinia Martin
15. Birthplace Germany

16 (a) Informant Mrs. Margaret S. Gralley
(b) Address Round Bay, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b)
AUG 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14, 1946, at 2:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1946 to Aug. 14 1946 and that I last saw h.e.r. alive on Aug. 14 1946.

Immediate cause of death	Duration
Acute dilatation of heart.	2 days
Due to Chronic Myocarditis	5 yrs.
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Scherbacher
M.D.
Address 1802 Eastern Ave Date signed 8-14-46

Huntington

G42911 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 ✓ Registered No. G42911

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St., 23
(c) Hospital or institution: Bon Secours Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore,
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Clifton Ave., (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Smoot (Infant)

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace 2025 W. Fayette St., Baltimore, Maryland

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Oval Leo Smoot
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Adelaide Kroh
15. Birthplace Baltimore, Maryland

16 (a) Informant Mary Adelaide Kroh Smoot (Mother)
(b) Address 3504 Clifton Ave., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15, 1946 (month) (day) (year)
(c) Cemetery St. Peters Cem.
Location Baltimore Md.

18 (a) Funeral director Wm. J. TIGNER & SONS INC.
(b) Address North & Pa Aves.

19 (a) (Date received by local registrar) (b) AUG 15 1946 Huntington Williams Reg. Bon Secours Hosp.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/46 19 ... at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1946 to Aug 14 1946 and that I last saw h alive on Aug 13 1946

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R Carr M.D.
Date signed 8/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42913 G42913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Ridgemede Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgemede Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GRACE EUNICE COLONELL

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank A. Colonell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1902

8. AGE: Years	Months	Days	If less than one day
43	7	19 20	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Steele
13. Birthplace N. Y.

MOTHER
14. Maiden Name Grace Friedele
15. Birthplace N. Y.

16 (a) Informant Mr. Frank A. Colonell
(b) Address Ridgemede Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Permit for burial

VS 150 AUG 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14, 1946, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 7, 1946 to August 14, 1946 and that I last saw her alive on August 10, 1946

Immediate cause of death Cachexia. — Duration

Due to Carcinoma, anaplastic, that arose from the posterior
Due to abdominal area, but the exact origin was not determined.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Biopsy of cervical gland.
of autopsy: None.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 11 E. Chase Street Date signed 8.14.46

X

G42913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G42913 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto. Gen Hosp 23
(d) Length of stay in hospital or inst. ~~[illegible]~~, or days) 2
(e) Length of stay in Baltimore (yrs., ~~months or days~~) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 E. WHEELING ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET FREDERICK
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-03-1194

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife JAKE H. FREDERICK
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) MAY 9, 1[illegible] (1906)
8. AGE Years 45 | Months 3 | Days 4 | If less than one day ..... hr. ..... min.
9. Birthplace BALTO MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name MARTIN WELSH
13. Birthplace BALTO, Md

MOTHER
14. Maiden Name MARY (?)
15. Birthplace BALTO Md.

16 (a) Informant Jake H. Frederick (Husband)
(b) Address 7 E. Wheeling St, Balto 30, Md.
17 (a) Burial — (b) Date thereof Aug 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Pulaski Hwy, Md.
18 (a) Funeral director H. Edmund Evans
(b) Address 4005 Eastern Ave, Balto 24, Md.
AUG 15 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 13 1946, at 8 45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from AUG 12 1946 to AUG 13 1946, and that I last saw h. ALIVE on AUG 13 1946.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	
Due to HYPERTENSION	
Due to ARTERIOSCLEROSIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. C. Eareckson M.D.
Address So Balto Gen Hosp Date signed 8/13/46

X

G42914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G42914 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2933 Huntingdon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2933 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Spann.

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kate E. Spann
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 31, 1876

8. AGE: Years	Months	Days	If less than one day
70	2	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Boiler maker
11. Industry or business Penna. R.R.

FATHER
12. Name Charles Spann.
13. Birthplace Germany.

MOTHER
14. Maiden Name Margaret Park.
15. Birthplace Maryland.

16 (a) Informant Kate E. Spann.
(b) Address 2933 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road.

18 (a) Funeral director Ebenezer B. Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Signature of registrar) Huntington Williams, M.D.

AUG 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1946 at 9 30/60 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 14 1946 and that I last saw h[illegible] alive on Aug 14 1946.

Immediate cause of death	Duration
(a) Congs. Heart Failure	
Due to (b) Arter. Atherosclerotic C-V. Dis.	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Hassman M. D.
Address 2032 Walbrook Date signed 8/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G42915
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2016 Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Honora Pleasants Kantner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Leahmer M. Kantner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
65?			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name Samuel Pleasants
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Irons
15. Birthplace Md.

16 (a) Informant Dr. Leahmer M. Kantner
(b) Address 2016 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) (Registrar)

AUG 15 1946

Huntington Wilson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12, 1946, at 10.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 23 1946 to Aug 12 1946 and that I last saw her alive on Aug 12 1946

Immediate cause of death: Carcinoma of Intestine-Metastasis to Lungs — Duration: about 4 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ✓

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide,
(b) Date of occurrence Aug at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 2818 St. Paul St. Date signed 8/13/46

X

G42916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓ Registered No. G42916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 N. MONROE St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILTON M. ROBINSON.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife GERTRUDE,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12.31.90

8. AGE: Years 65 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Operator B.T.C

11. Industry or business

FATHER
12. Name Inglis Robinson
13. Birthplace Cambridge

MOTHER
14. Maiden Name Ida Rinhart
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Gertrude Robinson
(b) Address 721 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14, 46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md.

18 (a) Funeral director L. HECHMANN & Son
(b) Address 32 S. BROADWAY.

19 (a) (Date received by registrar) AUG 15 1946 (b) Filed by registrar Washington Hollingsworth, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13th 1946 at 6.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 13 aug 1946 to 13 aug 1946 and that I last saw him alive on 13 aug 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Stella M. D.
Address St Jos Hosp Date signed 8-14-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G42917 Registered No.

1. PLACE OF DEATH: Union Memorial Hospital
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 W. Renwood Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Henry Hilgartner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Margaret W. Hilgartner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-1891

8. AGE: Years	Months	Days	If less than one day
54	11	0	hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation President of Marble Corp.
11. Industry or business Marble Corp.

FATHER
12. Name Charles L. Hilgartner
13. Birthplace Maryland.

MOTHER
14. Maiden Name Bianca Schrock
15. Birthplace Maryland.

16 (a) Informant Wife
(b) Address 1 W. Renwood Road, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Md.

18 (a) Funeral director H. W. Meade and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] Huntington Williams, M.D.

AUG 15 1946

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14, 1946, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12, 1946, to Aug. 14, 1946, and that I last saw h[illegible] alive on Aug. 14, 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to hypertensive cardiovascular disease	15 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr., M. D.
Address Union Memorial Hosp. Date signed 14 Aug '46

G42918 G42918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) three
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Echodale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John O'Boith O'Mailey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M.
6 (b) Name of husband or wife: Pauline
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan. 5- 1889
8. AGE: Years 58 | Months 7 | Days 9 | If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation clerk
11. Industry or business American Can Co

FATHER
12. Name John O'Mailey
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Hamilton
15. Birthplace Md.

16 (a) Informant Mrs. Pauline O'Mailey
(b) Address 4101 Echodale Ave. Balto
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory St Mary's, Location Laurel, Md
18 (a) Funeral director Leonard J. Cusick
(b) Address 5205 Harford Road.
19 (a) (Date rec'd by city registrar) (b) Registrar

AUG 13 1946 Huntington Williams, M.D.

JD 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 14 1946, at 11:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1946, to 8-14 1946, and that I last saw h.i.m alive on 8-14 1946.

Immediate cause of death Respiratory failure — Duration

Due to Cerebrovascular accident

Due to Hypertension

Other Conditions Congestive failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

73. Signature Walter L. Crouch M. D.
Address University Hospital Date signed 8-15-46

X

G42919 — BALTIMORE CITY HEALTH DEPARTMENT — G42919 Registered No.

CERTIFICATE OF DEATH

X 54a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8624 Oakleigh Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H Bonnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-16-39

8. AGE: Years	Months	Days	If less than one day
6	11	29	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Charles R Bonnett
13. Birthplace N.Y.

MOTHER
14. Maiden Name Rosemary Erickson
15. Birthplace Ohio

16 (a) Informant Mrs Charles F Bonnett
(b) Address 8624 Oakleigh Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/46 (month) (day) (year)
(c) Cemetery or crematory Gate of Heaven
Location New York

18 (a) Funeral director Leonard J Cook
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 19 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1946 at 6 45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 9 1946 to Aug 14 1946 and that I last saw h alive on Aug 14 1946

Immediate cause of death Post-operative Hemorrhage — Duration 4 months

Due to Tumor of Brain (medulloblastoma)

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 10 1946

Major findings of operation: Tumor of Cerebellum and fourth Ventricle

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur B King

Address Johns Hopkins Hospital Date signed 8/20/46

X

G42920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G42920
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. (D.O.A.)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD JOSEPH DUNN, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Teresa (nee Ritter)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1879

8. AGE: Years	Months	Days	If less than one day
67 yrs.	-	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Detective
11. Industry or business Baltimore City Police Dept.

FATHER
12. Name Edward Dunn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Olivia McKenna
15. Birthplace Ireland

16 (a) Informant Mrs. Theresa Ritter Dunn (wife)
(b) Address 427 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 15 1946 Huntington Hollowell, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13, 1946 at 8:45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1946, to Aug 1 1946, and that I last saw h[illegible] alive on Aug 1, 1946.

Immediate cause of death: Coronary Occlusion — Duration: 5 mos.
Due to: Coronary Thrombosis + Myocarditis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Hampson Jr. M. D.
Address 3503 Fait ave. Date signed Aug 13 '46

X

G42921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164B

Registered No. G42921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3826 Old Frederick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Cahan, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife June 1 1925

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1925

8. AGE: Years	Months	Days	If less than one day
21	2	9	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Michael J Cahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Josie E. Murphy
15. Birthplace Ireland

16 (a) Informant Michael J Cahan
(b) Address 3826 Old Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Catacombs
Location Baltimore Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Fayette

19 (a) (Date received by registrar) (b) Registrar

AUG 15 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1946, at 1 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-10- at 1 P. M.
(b) Where did injury occur? 7 Fork Knob, Chesapeake Bay
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped (?) from S.S. Bear Mountain

23. Signature Howard J. Mueller M.D.
Medical Examiner

Date signed 8-13-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G42922 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lexington St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Leahy,

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Michael Leahy,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
about 70			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Sauer,
13. Birthplace Germany,

MOTHER
14. Maiden Name unknown,
15. Birthplace Germany,

16 (a) Informant Mrs. J.A.McLaughlin,
(b) Address 3216 Evergreen Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer,
Location Baltimore City,

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13, 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 19 46 to 8/13 19 46
and that I last saw her alive on 8/13 19 46

Immediate cause of death Mitral insufficiency

	Duration
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Siscovick M. D.
Address 1429 W. Fayette St. Date signed

VS 150 AUG 15 1946 Huntington Williams, M.D. Registrar

Siscovick X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G42923 G42923 Registration No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dread & Bedelwood
(c) Hospital or institution: Univ. Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) ? 14th
(e) Length of stay in Baltimore (yrs., mos., or days) ? 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 W. Lanvale St
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Peter Jim (Peter JIM)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	Chinese	married

6 (b) Name of husband or wife (T-Tong Ha-?) Unknown
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Nov. 15-1882

8. AGE: Years	Months	Days	If less than one day
63	8	29	hr. min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mr. Sing Tong Lee (Friend)
(b) Address 1538 W. Lanvale St - City
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk
Location Woodlawn Md.
18 (a) Funeral director Stewart D. Worden Co.
(b) Address 111 W. North Ave. - City
19 (a) (Date received by registrar) AUG 15 1946 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1946, at 7 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946 to Aug 14 1946, and that I last saw him alive on Aug 14 1946

Immediate cause of death	Duration
Myocardial failure	
Due to Hypertension	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. McCurdy M. D.
Address University Hospital Date signed 8-14-46

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √31a

Registered No. G42924

G42924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Addie McDaniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Sumter, S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edwin McDaniels
13. Birthplace S. C.

MOTHER
14. Maiden Name Lydia Wilson
15. Birthplace S. C.

16 (a) Informant Addie McDaniels
(b) Address 1316 N. Bond St.

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Pk.
Location
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brasfield Ave. Huntington Williams, M.D.
AUG 15 1946 (Date filed by Registrar) Registrar

8/13/46 **MEDICAL CERTIFICATION** 12:30 AM

20. DATE OF DEATH 8/13/1946 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Aug 8 1946 and that I last saw h alive on Aug 1946

Immediate cause of death Cardio-Renal Hypertension Disease — Duration 7 1

Due to

Due to

Other Conditions Regimen Colitis ? !

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj Stone M. D.
Address 1207 N Carlin Date signed 8/14/46

VS 150

X

G42925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G42925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4436 Rospe Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cecilia Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 55

8. AGE: Years	Months	Days	If less than one day
90	8	20	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Elliott

13. Birthplace MD

MOTHER 14. Maiden Name Nancy Brandenburg

15. Birthplace Harford Co. Md

16 (a) Informant Mrs. Raymond Cayce

(b) Address 4436 Rospe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-46 (month) (day) (year)

(c) Cemetery or crematory VERNON

Location White Hall, MD

18 (a) Funeral director Hamel & Magdeline

(b) Address White Hall, Md.

19 (a) Date received AUG 15 1946 (b) Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1946, at 9 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1946 to 8/15 1946 and that I last saw her alive on 8/15 1946

Immediate cause of death: Circulatory failure — Duration

Due to Arterio-sclerosis

Due to old age & diabetes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Howard W. Stills Jr. M.D.

Address Mercy Hospital Date signed 8/15/46

VS 150

G42926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

G42926 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3614. Lyndale ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3614. Lyndale ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna. M. Hill.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-24-9669

4. Sex Female. | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William L. Hill

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) November 14. 1887

8. AGE: Years 56. | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Joseph J. Rittes

13. Birthplace Baltimore Md.

14. Maiden Name Anna M. Price

15. Birthplace Baltimore Md.

16 (a) Informant William L. Hill

(b) Address 3614. Lyndale ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Rendall-Hippel

(b) Address 312. S. Highland ave

19 (a) (b) (Signature of registrar) Huntington Williams M.D.

AUG 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1946, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946, to Aug 13 1946 and that I last saw her alive on Aug 12 1946.

Immediate cause of death: Carcinoma of Breast with metastasis. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. B. Stevens M.D.

Address 3400 Erdman ave Date signed 8/19/46

6-1298 M 6-28-108704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. 042927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Martha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? (59?

8. AGE: Years	Months	Days	If less than one day
59 ?	?	?	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name Mae White
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Pont · Balto. Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 9 27 N. Mount St.

AUG 15 1946 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1946 to 8-14 1946 and that I last saw h 13 alive on 8-14 1946.

Immediate cause of death: Uremia — Duration: 1 mo.

Due to Arteriosclerotic CVD — yrs.

Due to

Other Conditions P.O. S.T.S.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Beasley M.D.
Address Balto City Hosp Date signed Aug 7 46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G42928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G42928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Streets
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Forrest

3 (b) If veteran, name war: No

3 (c) Social Security Account No. Unknown

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Forrest
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1876

8. AGE: Years 69 | Months 10 | Days 11 | If less than one day: hr. min.

9. Birthplace St. Mary's County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

MOTHER / FATHER
12. Name Joseph Bennett
13. Birthplace Raleigh, N.C.
14. Maiden Name Unknown
15. Birthplace St. Mary's County, Md.

16 (a) Informant Rose Daley
(b) Address 84 DeGrange St, Frederick Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Wm. Peter R. Williams
(b) Address 3229 N. Edmondson Av.

19 (c) Date received by local registrar AUG 15 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 August 1946, at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Aug 1946 to 13 Aug 1946, and that I last saw h/m alive on 12 Aug 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration:

Due to: Hypertensive Cardio-Renal Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Franklin Sq Hosp Date signed 8/13/46

G42929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G42929 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 Brantley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Brantley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD WISE

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9088

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lena Lelia Wise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1891

8. AGE: Years	Months	Days	If less than one day
55	4	15	hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name George Wise
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Broom
15. Birthplace Md.

16 (a) Informant Mrs. Lena Lelia Wise
(b) Address 1019 Brantley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) AUG 15 1946 (Registrar) (b) Registrar

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 13, 1946 at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1946 to 8/13 1946 and that I last saw him alive on 8/12 1946

Immediate cause of death: Acute Myocarditis

Duration
7/8
1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Hatch

Address 1 W Preston St Date signed 8/14/46

X

G429.50 G42930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 150

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Nursing Home St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 3 mos. 8 da. How long in U. S. If of foreign birth? yrs. mos. da.

If U. S. Veteran specify WAR

2. FULL NAME Reginald Heber Murphy

(a) Residence: No. 115 W. Monument St., 11-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M.	Wa	W.

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Roberta Murphy (nee Foster)

6. DATE OF BIRTH (month, day, year) Sept 11, 1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Railroad

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Conductor

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Lenard town Md

FATHER

13. NAME Reginald Heber Murphy

14. BIRTHPLACE (city or town) (State or country) Dont know

MOTHER

15. MAIDEN NAME Elizabeth Simmons

16. BIRTHPLACE (city or town) (State or country) Ft Arkana Kansas

17. INFORMANT Reginald Heber Murphy Jr.
(Address) 115 W. Monument St. Balto

18. BURIAL, CREMATION, OR REMOVAL
Place All Saints Cem. Date Aug. 16, 1946

19. UNDERTAKER Wm. Berryman & Sons "Relaterstown, md.

20. FILED AUG 15 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 14, 1946

22. I HEREBY CERTIFY, That I attended deceased from April 6 - 1946 to Aug 14 - 1946

I last saw h alive on Aug 14, 1946 Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Breast Indefy

Date of onset

Other contributory causes of importance

Exhaustion 3 days

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

(Signed) D. A. Richardson M. D.

(Address) 112 W. 25th St

X

*State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G42931 Infant Caldwell D-04235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G42931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hr. 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED: Newborn
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 Sarahamm St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Berry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1946

8. AGE: Years	Months	Days	If less than one day
			20 hr. 45 min.

9. Birthplace Baltimore City, Md. (Town, county, and state)
10. Usual Occupation New born
11. Industry or business

FATHER
12. Name John Louis Berry
13. Birthplace ?, North Car.

MOTHER
14. Maiden Name Louise Caldwell
15. Birthplace Greensburg, N. C.

16 (a) Informant Louise Berry (Mother)
(b) Address 636 Sarah Anne St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical School AUG 15 1946
18 (a) Funeral director Commissioner of Health
(b) Address
AUG 15 1946 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1946, at 6 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10, 1946 to Aug 11 1946, and that I last saw him alive on Aug 11, 1946.

Immediate cause of death Intracranial Hemorrhage — Duration

Due to (probably) Breech Delivery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George L. Lennox M. D.
Address Univ. Hosp. Date signed Aug 12 '46

X

G42932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G42932 Registered No.

124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Streets
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24days
(e) Length of stay in Baltimore (yrs., mos., or days) 24days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Sussex
(c) City or town Stoney Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. Near Court House of Sussex (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick J. Jackson

3 (b) If veteran, name war	3 (c) Social Security Account No.
Unknown	Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna Deitrich
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 18, 1888

8. AGE: Years	Months	Days	If less than one day
58	2	27 28	hr. min.

9. Birthplace Stoney Creek, Va (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Self

FATHER
12. Name Benjamin Jackson
13. Birthplace Virginia

MOTHER
14. Maiden Name Effie Moss
15. Birthplace Virginia

16 (a) Informant Fanny Mitchell
(b) Address Latrobe Apts, Balto, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/15/46 (month) (day) (year)
(c) Cemetery or crematory
Location Petersburg, Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) [illegible] (b) [illegible] Registrar

AUG 15 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 August 1946, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 July 1946, to 15 August 1946, and that I last saw h/m alive on 15 August 1946.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Deitrich
Address Franklin Sq Hosp Date signed 8/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42933 St Joseph's 678 Washington Blvd Ba 1555 G42933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 W. Barre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 W. Barre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel E. Muller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	White	Married

6 (b) Name of husband Fred H. Muller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2nd 1893

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	3	12		

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Samuel Mason
13. Birthplace North Carolina

MOTHER
14. Maiden Name Alonzo Anderson
15. Birthplace Balto. Md.

16 (a) Informant Fred H. Muller
(b) Address 815 W. Barre St.

17 (a) Burial (b) Date thereof 8/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address St. Paul St.

19 (Signature of local registrar) Huntington Williams, M.D.
Registrar

AUG 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14th 1946. 6 20 2. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1946 to 8-14 1946, and that I last saw him alive on 8-14 1946

Immediate cause of death: Acute Cardiac Failure — Duration 10 d

Due to: Carcinoma of cervix with Metastases — Duration yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G Loweath M.D.
Address 678 Washington Blvd Date signed 8/14/46

VS 150

G42934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

Registered No. G42934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Streets
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 O'Dell Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-0966

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise Moore
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 23, 1894

8. AGE: Years	Months	Days	If less than one day
52	4	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation STATIONERY ENGINEER
11. Industry or business SHIP BUILDING

FATHER
12. Name [illegible] Moore
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Emily [illegible] Hedreck
15. Birthplace Balto, Md

16 (a) Informant James Moore
(b) Address 1700 O'DELL AVE Balto, Md

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 16 '46 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location City

18 (a) Funeral director JOHN R. KENNY
(b) Address 1242 LEEDS TERRACE

AUG 16 1946 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 August 1946, at 8:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 July 1946, to 13 Aug 1946 and that I last saw h[illegible] alive on 13 Aug 1946.

Immediate cause of death Internal Hemorrhage — Duration

Due to Cancer of Pancreas and Cancer of Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 8/13/46 -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar Southwick M.D.
Address Franklin Sq. Hosp. Date signed 8/14/46

G42935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G42935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 Fait Ave
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RUR and give town)
(d) Street No. 2421 Fait Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Norwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/[illegible]

8. AGE: Years	Months	Days	If less than one day
79	10	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Charles Lowell
13. Birthplace Balto.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mary Lowell
(b) Address 2615 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Dy
(b) Address 1403 E. Monument St.

19 (a) AUG 16 1946 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug 1946, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Aug & Insp thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Kelly M.D.
Medical Examiner
Date signed 14 Aug 46

VS 151

X

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57D

Registered No. G42936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4418 Raspe Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4418 Raspe Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris E. Langhery

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry E. Langhery

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) March 30 1903

8. AGE: Years 33 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER 12. Name J. Milton Kahline
13. Birthplace Baltimore

MOTHER 14. Maiden Name Margaret Bush
15. Birthplace Baltimore

16 (a) Informant Harry E Langhery
(b) Address 4418 Raspe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16, (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem
Location Rosedale

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Eastern Ave

19 AUG 14 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1946 to 8/12 1946 and that I last saw him alive on 7/29 1946

Immediate cause of death BRAIN TUMOR — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature [illegible] M. D.
Address 6331 Belair Rd Date signed 8/13/46

VS 150

G42937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G42937
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Washington Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Ventuella

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10-1867

8. AGE: Years 78 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Shoemaker
11. Industry or business

FATHER 12. Name Frank
13. Birthplace Italy

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Frank V
(b) Address 804 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19-1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Fazace Inc.
(b) Address 2015 Greenmount Ave
(Date received by registrar) AUG 16 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-1946, at 5:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1941, to 8-14 1946, and that I last saw h alive on 8-14 1946.

Immediate cause of death Acute Heart Failure | Duration

Due to Chronic Myocarditis

Due to Pernicious Anemia

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis V. Lamm M. D.
Address 876 Worlent Ave Date signed 8/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42938
CMH-16167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G42938
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10- 7- 5- 26-12
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hebrew Friendly Inn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Tramer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1887

8. AGE: Years	Months	Days	If less than one day
59	3	16	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leopold Tramer (D)
13. Birthplace ?

MOTHER
14. Maiden Name Rose ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Pevins Inc
(b) Address 1439 E. Balto St

19 (a) AUG 16 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 14 1946, at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1946, to Aug. 14 1946, and that I last saw him alive on Aug. 14 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alvin S. Hartz
Address Balto City Hosp Date signed 8-15-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42939 ✓ 83 B

Registered No. G42939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 No Ellamont St
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Kloze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years: 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, State or country)

10. Usual Occupation Master Plumber

11. Industry or business

FATHER
12. Name Morton
13. Birthplace Russia

MOTHER
14. Maiden Name Zlotkin Kelly
15. Birthplace Russia

16 (a) Informant Abr. Kloze
(b) Address 3314 Farrington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] 8-16-46 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Bros
(b) Address 1419 E. Balto St

19 (a) (Date rec'd by registrar) AUG 16 1946 (b) Registrar Huntington Williams

VS 190

MEDICAL CERTIFICATION

22. DATE OF DEATH 8-15-1946, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1946, to 8/15 1946, and that I last saw him alive on 8/15 1946.

Immediate cause of death: Cerebral Embolism — Duration: 1 day
Due to: General Arteriosclerosis — 1945
Due to: — 1947
Other Conditions: Epilepsy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 432 E. Lexington St Date signed 8/15/46

G42940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G42940
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2468 Lakewood Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Kaufman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Minnie Kaufman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 14 1874

8. AGE: Years 72 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business Ladies Wear

FATHER
12. Name Emanuel Kaufman
13. Birthplace Germany

MOTHER
14. Maiden name Betty Gundersheimer
15. Birthplace Va.

16 (a) Informant Mrs. L. Lipman
(b) Address 906 Whitelock St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sondheim & Son
(b) Address 1902 Eutaw Place

19 (Date rec'd by registrar) AUG 16 1946 Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946, at 9:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 23, 1946, to August 14 1946; that I last saw him alive on August 14, 1946.

Immediate cause of death: Pulmonary Tuberculosis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not Held

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. K. Brickman, M. D.
Address Sinai Hospital Date signed 8/14/46

Dr. Wm. Mitchell
~~G12941~~ 10 West Madison St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 E

Registered No. G12941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5222 Biddison Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5222 Biddison Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna De Cicco

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Saverio F. De Cicco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1869

8. AGE: Years	Months	Days	If less than one day
77	1	23	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Alphonse De Cicco
(b) Address 5222 Biddison Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Registrar

AUG 16 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946 to Aug 15 1946. And that I last saw her alive on Aug 13 1946.

Immediate cause of death: Cardiac Failure — Duration 6 months

Due to Coronary Thrombosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Mitchell M.D.
Address 10 W. Madison Date signed 8/16/46

VS 150

G12942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CHK-102467

Registered No. 462 G42942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 14-
(e) Length of stay in Baltimore (yrs., mos., or days) 55- 8- 5-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horrow Hicks

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8-1890

8. AGE: Years	Months	Days	If less than one day
55	8	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Hicks (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel Hicks
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bloomfield Ave
(c) Date received AUG 16 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1946 to Aug. 13 1946, and that I last saw h im alive on Aug. 13 1946.

Immediate cause of death: Cardiac failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-10-46

Major findings of operation: Ca of pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry L. Rigdon M. D.
Address BCH Date signed 13 Aug 46

X

G42943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G42943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Cranston Ave, #2. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles Howard Neilson.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1898

8. AGE: Years	Months	Days	If less than one day hr.	min.
47	10	27		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name Edward McLain Neilson
13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Florence Armiger
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Edward Amspacher
(b) Address Stewartstown, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar

AUG 16 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1946, at 10:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug. 15 1946 and that I last saw h[illegible] alive on Aug. 15 1946.

Immediate cause of death: Pulmonary Embolism

Due to Cardiac decompensation

Due to Arteriosclerotic heart disease with Coronary sclerosis and Thrombosis.

Other Conditions Carcin[illegible] Ca. cardiac hypertrophy (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Campbell M. Kilpatrick Jr.
Address Union Mem. Hosp. Date signed 8-15-46

G42944 Birth Certificate D-53830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓160 a

G42944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl "A" Catalano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14 1946

8. AGE: Years	Months	Days	If less than one day
		1	39 hr. 15 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sam Catalano
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Zeok
15. Birthplace Roma - Italy

16 (a) Informant Sam Catalano Father
(b) Address 1703 E. Lombard St

17 (a) Burial (b) Date thereof Aug 16 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Balt. Md

18 (a) Funeral director Frank Waller Sons
(b) Address 52 N. Monroe St

19 (a) (b)
(Date received by registrar) (Signature of registrar)
AUG 16 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1946 at 3 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1946 to 8/15 1946 and that I last saw h[illegible] alive on 8/15 1946.

Immediate cause of death Respiratory paralysis. — Duration

Due to Intracranial hemorrhage

Due to birth trauma

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Leuenton M.D.
M. D.
Address Univ Hosp Date signed 8/15/46

Birth Certificate

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G42945 B-53470 160 C Registered No. G42945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Dundalk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Stone

3 (b) If veteran, name war: | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			10 hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Dolor Stone
13. Birthplace

MOTHER 14. Maiden Name Iris. Stone
15. Birthplace Wynn.

16 (a) Informant Father
(b) Address 1923 Dundalk Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-16-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director J. H. McCauley
(b) Address 130 S. Fort Ave.

AUG 16 1946 (Date rec'd by Local Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1946, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1946, to 8/15 1946, and that I last saw h[illegible] alive on 8/14 1946.

Immediate cause of death Aspiration of amniotic fluid intrauterine — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Lungs filled w. amniotic fluid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Stuart D. Rizika
Address St. Agnes Hosp. Date signed 8/15/46

G42946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1245

G42946
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3514 4th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 4th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Canby

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife William F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/1881

8. AGE: Years	Months	Days	If less than one day
65	4	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Follin
13. Birthplace Md.

MOTHER
14. Maiden Name Georgiana Armsworthy
15. Birthplace Md.

16 (a) Informant Family
(b) Address 3514 4th St.

17 (a) Be (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie

18 (a) Funeral director L. M. Cauley
(b) Address 130 S. Fort Ave.
(c) Licensed embalmer (Signature of registrant) Huntington Williams, M.D.

AUG 16 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1946, at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1946, to Aug 15 1946, and that I last saw h[er] alive on Aug 15 1946.

Immediate cause of death: Arteriosclerotic cardiovascular renal disease — Duration 2½ yrs

Due to

Due to

Other Conditions Carcinoma of breast — 2 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Kahs, M.D.
Address 1026 Fulton Date signed 8/16/46

1312

G42947.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G42947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 N. Gilmor Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 N. Gilmor Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME William Edward Johnson

3 (b) If veteran, name war: No.
3 (c) Social Security Account No. 212-05-3689A
4. Sex: MALE
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: Gertrude Johnson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 7, 1876
8. AGE: Years 70 Months 1 Days 11 If less than one day hr. min.
9. Birthplace ESSEX County, VA. (Town, county, and state)
10. Usual Occupation Retired (Porter)
11. Industry or business

FATHER
12. Name RICHARD Johnson
13. Birthplace Essex County, VA.

MOTHER
14. Maiden Name HARRIET ?
15. Birthplace Essex County, VA.

16 (a) Informant PAUL JOHNSON, SR.
(b) Address 810 W. LEXINGTON, St. Apt. 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18. 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Anne Arundel County
18 (a) Funeral director Joseph A. Cinefro
(b) Address 6/19 East Baltimore St
AUG 16 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 10, 1946, to August 13, 1946, and that I last saw h[illegible] alive on August 12 1946

Immediate cause of death: CARDIAC Failure — Duration: Several Hrs.
Due to: CARCINOMA of Colon — 17 Months
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt
Address 607 W. Mulberry St. Date signed 8/13/46

G42948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15 —

G42948 Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 W. Saratoga St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Chandler

3 (b) If veteran, name war —

3 (c) Social Security Account No. 250-18-4493

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col	Married

6 (b) Name of husband or wife Emma Chandler

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 8 6 1911

8. AGE: Years	Months	Days	If less than one day
35	0	9	— hr. — min.

9. Birthplace Sumpter S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name William Chandler

13. Birthplace — S.C.

14. Maiden Name Estelle Lowery

15. Birthplace " S.C.

16 (a) Informant Emma Chandler

(b) Address 727 W. Saratoga St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 17 1946 (month) (day) (year)

(c) Cemetery or crematory Sumter S.C.

Location

18 (a) Funeral director Mrs Katie P Williams

(b) Address 322 W. Lombard St

AUG 16 1946 (Date received by Registrar) Washington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1946, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946 to Aug 15 1946 and that I last saw living alive on Aug 15 1946

Immediate cause of death Broncho-Pneumonia — Duration 1 Day

Due to Post-Operative.

Due to

Other Conditions Intestinal Tuberculosis.
(Include pregnancy within 3 months of death)

Date of operation June 18, 1946.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Lightstone M. D.

Address 501 Cherry Hill Rd Date signed 8/15/46

G12949

CWK-91518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G12949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 7- 5-
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3551 Sweet Air Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie McDonald

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10-1868

8. AGE: Years	Months	Days	If less than one day
78	1	5	hr. min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John R. Groves
13. Birthplace Virginia

MOTHER
14. Maiden Name Nancy Hoffman
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Removal (b) Date thereof Aug. 16, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Natl Cem.
Location Arlington, Va

18 (a) Funeral director S. H. Hines Co.
(b) Address 1961-14th St N.W. Washington, D.C.

AUG 16 1946
(Date rec'd by registrar) Washington, D.C.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1944 to Aug. 15 1946, and that I last saw h 8F alive on Aug. 15 1946

Immediate cause of death Bronchopneumonia

Duration

Due to Hypertension & C-V Disease Coronary Artery Disease.

Due to

Other Conditions Generalized Arteriosclerosis Diabetes Mellitus. Parkinsonism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto City Hosp Date signed 8-15-46

92D

C42950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C42950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Milford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Milford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ann Isaacs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Walter Wade Isaacs

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 15 1888

8. AGE: Years 57 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER — 12. Name Charles William Grant
13. Birthplace Frederick Co, Va.

MOTHER — 14. Maiden Name Virginia Wilson
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. W. Isaacs
(b) Address 3009 Milford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Bertram Dove
(b) Address 2330 Charles St

AUG 16 1946 (Date received by Registrar) (b) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1946 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 1946 to Aug. 15 1946 and that I last saw h alive on Aug 5 46

	Duration
Immediate cause of death Carcinoma Breast	3 yr.
Due to Pulmonary Edema	3 day
Due to	
Other Conditions Pulmonary Edema & Uremia Metastases	6 mo?

(Include pregnancy within 3 months of death)

Date of operation Dec. 1943
Major findings of operation: Carcinoma Breast
of autopsy: (Detailed)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo Sattler MD
Address 1600 Liberty Hts Ave Date signed 8/15/46

G42951 G42951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Kiski
(If outside city or town limits, write RURAL and give town)
(d) Street No. 551 North St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Mundrick Mundrock. (MUDROCK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-41

8. AGE: Years 5 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Mundrock
13. Birthplace Pa.

MOTHER 14. Maiden Name Rose Quarnick
15. Birthplace Pa

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 16/46 (month) (day) (year)
(c) Cemetery or crematory: St Mary's
Location: Kiski, Pa.

18 (a) Funeral director: John A. Mitchell & Son
(b) Address: 1900 Eutaw Place

19 (a) (Date first visited deceased) (b) Registrar

AUG 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1946, at 2.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1946, to Aug. 16 1946, and that I last saw him alive on Aug. 16, 1946.

Immediate cause of death: Cerebral Embolism — Duration: 14 hours
Cerebral thrombosis
Due to Polycythemia
Due to Tetralogy of Fallot — Duration: Birth
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation 8/16/46
Major findings of operation: Pulmonary stenosis, tetralogy of Fallot
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Henry F. Bahrenburg Date signed 8/16/46 M. D.

G42952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

G42952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4908 - Curtis Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
? 60			hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Chas. D. Schneider
(b) Address 1600 Areal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 AUG 16 1946 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1946, at 10:57 a.m.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic myocardial degeneration

Due to

Other Conditions Hypertension + Asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masseni M.D.
Medical Examiner.
Date signed 8/15/46

G42953 G42953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jeanne O'Neil (Sister Edith of St Patrick)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Religious

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1. 1858

8. AGE: Years	Months	Days	If less than one day
88	5	14	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward O'Neil
13. Birthplace Ireland

MOTHER
14. Maiden Name Bergh Jane McCallon
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address Boordalley Street City

17 (a) Burial (b) Date of (Burial, cremation, or removal) Aug 17. 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wredefeld
(b) Address 905 E. Biddle St. Huntington Williams, Mgr.

19 (a) AUG 16 1946 (Registrar) (b) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1946 at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Aug 15 1946 and that I last saw h alive on Aug 16 1946

Immediate cause of death	Duration
(a) Postfinal obstruction due to mass in abdomen	
Due to (b) Causing death from toxemia	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Otto H. Duker M. D.
Address 928 E. North Ave Date signed 8/15/46

G42954 Birth Certificate D-54223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓160C

G42954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp. ✓0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. - 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Linwood St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Compton

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 13 Aug 46

8. AGE: Years	Months	Days	If less than one day
		2 1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Stanley J Compton
13. Birthplace Va.

MOTHER
14. Maiden Name Bertha L Reese
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 16 1946

18 (a) Funeral director Commissioner of Health
(b) Address
AUG 16 1946 (Date rec'd by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug 1946, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Aug 1946, to 14 Aug 1946, and that I last saw h[illegible] alive on 14 Aug 1946.

Immediate cause of death Pre-maturity, 6½ mo.
Pre matre detachment Placenta
Due to Hemorrhagic diasis
Type) undetermined.
Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Hemorrhagic Disease

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of plane)
(e) Means of injury
23. Signature Harry Cohen
Address Sinai Hosp Date signed 15 Aug 46

G42955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G42955 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 Maydell Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Maydell Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frey

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis M Frey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1872

8. AGE: Years	Months	Days	If less than one day
73	9	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER — 12. Name	Conrad Thater
FATHER — 13. Birthplace	Germany
MOTHER — 14. Maiden Name	Adeland Rauch
MOTHER — 15. Birthplace	Germany

16 (a) Informant Mrs Edna Richardson
(b) Address 302 Maydell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1946 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Balto
Funeral director Chas Hayward Evans
Address 1400 St Paul St
Date of registration Aug 17 1946 Registrar Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1946 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Aug 16 1946 and that I last saw her alive on Aug 14 1946.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Cardio Vascular Renal Disease & Hypertension	10 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elliot W Johnson M.D.
Address 2432 Madison Ave Date signed

G42956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42956
Registered No.

30a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give name of county)
(d) Street No. 201 NORTH POINT RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDA. KOET.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4.28.03

8. AGE: Years 43 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business Own Home

FATHER
12. Name Philip Kaxow
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Schwartz
15. Birthplace Russia

16 (a) Informant George Koet
(b) Address 201 North Point Rd.

17 (a) Burial (b) Date thereof 8/19/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Baltimore Co Ex'td

18 (a) Funeral director Wellington Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received by Registrar AUG 17 1946
(b) Registration No. Wellington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1946 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8.14.46 19 to 8.16.46 19 and that I last saw her alive on 8.16.46 19

Immediate cause of death: Cardio-respiratory failure

Due to Bronchopneumonia

Due to Lobar pneumonia, right.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H Young M.D.
Address St. Joseph Hosp. Date signed 8/16/46

G42957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G42957 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Coldspring Lane
(c) Hospital or institution:
Old Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 W Lexington St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME James Joseph Clarke Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Mary M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1865

8. AGE: Years	Months	Days	If less than one day
81	4	28	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business Retired

FATHER
12. Name Unknown Clarke
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John L. Clarke
(b) Address 2312 W Lexington St

17 (a) Burial (b) Date thereof Aug 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director H. M. Cook Inc
(b) Address 5 Light Preston Sts Balto Co Huntington Maryland

19 (a) 1946 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1946, at 5:06 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to August 15 1946 and that I last saw him alive on Aug. 15 1946.

Immediate cause of death: Hypostatic Pneumonia — Duration 2 days.
Due to Arteriosclerotic Heart Disease — 10 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Kleiman M.D.
Address 3803 Edmondson Ave Date signed 8/16/46

KLEIMAN

VS 150

G42958

CHK-108595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G42958

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 62- 11- 28-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N. 24th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Schell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17-1883

8. AGE: Years	Months	Days	If less than one day
62	11	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter Schell
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Aug 17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Frederick Road

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 E. Paul Street

19 Aug 7 1946 (b) Washington Williams, Mgr.
(Date rec'd by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1946 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1946, to Aug. 15 1946, and that I last saw h er alive on Aug. 15 1946

Immediate cause of death	Duration
Hypertensive Cardiovascular disease	5 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Russell Hoffman
Address Baltimore City Hall Date signed Aug 7 1946

G42959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G42959 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 E. 35th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie Tawney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Eugene Tawney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12th 1864

8. AGE: Years	Months	Days	If less than one day
82	5	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name George Gardner
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Frazier
15. Birthplace Md.

16 (a) Informant Miss Grace Dickey
(b) Address 616 E. 35th St.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

(Date rec'd by registrar) (b) Huntington Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16th 1946, at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June, 1946 to Aug, 1946 and that I last saw her alive on Aug. 14 1946

Immediate cause of death: Cardiac decompensation — Duration: Several months

Due to Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Henry Hoover M. D.
Address 4218 Hoyt Rd Date signed 8/16/46

VS 150

G42960 Birth Certificate
4-53903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G42960
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Poplar Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Littleton (Michael T. Littleton)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 46

8. AGE: Years | Months | Days | If less than one day: 2½ hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Morgan A Littleton
13. Birthplace Balto Md

MOTHER
14. Maiden Name Margaret A. Thome
15. Birthplace Balto. Md.

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 Old Frederick Rd
18 (a) Funeral director Harry H Withers
(b) Address 4101 Edmondson Ave.
19 (a) 1946 (b) by me Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Aug 15 1946 and that I last saw him alive on Aug 15 1946

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert J. Sheldon
Address Date signed 8/19/46

VS 150

G42961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G42961
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Berly Richard Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-12-0810

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1922

8. AGE: Years	Months	Days	If less than one day
24	3	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Defense worker
11. Industry or business

FATHER
12. Name Richard Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Blanche Jackson
15. Birthplace Baltimore Md.

16 (a) Informant Blanche Williams
(b) Address 406 Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17 1946 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Jno. George H. Holland
(b) Address 1631 Druid Hill Ave

17 1946 Huntington Williams M.D. Registrar
(Filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1946, at 1.06 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946, to Aug 17 1946, and that I last saw him alive on Aug 14 1946.

Immediate cause of death Leukemia Myelogenous Chronic — Duration 4 Months

Due to

Due to

Other Conditions Pulmonary Tbc + Pericarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury MEYER H. ZURAVIN
23. Signature George H. Zuravin M.D.
Address 2231 Eutaw Place Date signed 8/16/46

VS 19A

G42962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G42962 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Glover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George J. Bien

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-3313

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Adelaide
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1887

8. AGE: Years	Months	Days	If less than one day
59	4	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name John Bien
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Thoms
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2824 Orleans St.

AUG 17 1946 (Date rec'd by registrar) (b)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1946, at 7:55P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1946, to Aug. 15 1946, and that I last saw h. im alive on Aug. 15 1946

Immediate cause of death Diabetes mellitus — Duration 10 years

Due to

Due to

Other Conditions Tuberculosis pulmonary — Duration 5 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. Russell Magruder M. D.

Address Baltimore City Hosp. Date signed Aug. 19 46

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G42963 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Copley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Copley Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A. Thomas

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 212-18-2547

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Evelyn N. Thomas
6 (c) If dead, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 9-1890

8. AGE: Years	Months	Days	If less than one day
56	3	6	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Warner Bros.
11. Industry or business Motion Pictures

FATHER
12. Name William Thomas
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Tinkerhour
15. Birthplace

16 (a) Informant Evelyn N. Thomas
(b) Address 3809 Copley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-46 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington Va.

18 (a) Funeral director Odell Funeral Home Inc.
(b) Address 4644 Yorke Road

19 (a) (b) Washington Williams, Registrar

AUG 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1946, at 10.50 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Kelfrich M.D. Medical Examiner
Date signed 16 Aug 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G42964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

G42964 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. Carrollton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N. Carrollton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bennett
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Flora Bennett
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1894
8. AGE: Years 52 Months Days If less than one day hr. min.
9. Birthplace Balto, Md
(City, county and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Chas. Bennett
13. Birthplace St Mary's Co Md

MOTHER
14. Maiden Name Anna Butler
15. Birthplace St Mary's Co

16 (a) Informant Mrs Flora Bennett
(b) Address 1105 N. Carrollton
17 (a) Burial (b) Date thereof 8/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Gilbertus
Location Md
18 (a) Funeral director Geo. H. Kelson
(b) Address 1350 Pennsylvania Ave
(c) Date received by Registrar AUG 17 1946 (d) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/46 at 11 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1946 to 8/17 1946 and that I last saw him alive on 8/15/46.
Immediate cause of death
Due to Cerebral Hemorrhage
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy?

Duration
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. W. Elcock
Address 1131 Harlem Date signed 8/17/46

G42965

CMS-100927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G42965

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 17-
(e) Length of stay in Baltimore (yrs., mos., or days) 75- 11- 14

8 1/2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Etzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2-1870

8. AGE: Years	Months	Days	If less than one day
75	11	14	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Reid Etzel
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Koehler (D)
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 8/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) Huntley L. Williams, M.D.

AUG 17 1946

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 16 1946, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1946 to Aug. 16 1946 and that I last saw her alive on Aug. 16 1946.

Immediate cause of death: Bronchopneumonia, postoperative — Duration: 1 week

Due to

Due to

Other Conditions Intertrochanteric fracture - left femur. H.C.V.D.
(Include pregnancy within 3 months of death)

Date of operation 7-12-46

Major findings of operation: Above fracture

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-25-46 at 8:15 M
(c) Where did injury occur? 1526 N. Broadway (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Tripped & fell at home

23. Signature Maureen M. Lacy M. D.
Address Baltimore City Hosp. Date signed 8-16-46

Subject to the approval of Medical Examiner Howard J. Madeira M. D.

G42966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G42966
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2817 Pinewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Pinewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL E. BURNS

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Minnie Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Robert E. Burns
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Mr. Samuel L. Burns
(b) Address 2817 Pinewood Ave. 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar

AUG 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1946, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1942 to Aug 2 1946 and that I last saw him alive on Aug 12 1946.

Immediate cause of death Coronary thrombosis Duration Sudden

Due to Chronic coronary sclerosis

Due to Hypertension Chronic myocarditis

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold

Address 4216 Harford Road Date signed M. 8 D. 16/46

G42967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G42967 Registered No. 131B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Duvaland & Rayner Ave
(c) Hospital or institution:
West Baltimore General Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 68
(If outside city or town limits, write RURAL and give town)
(d) Street No. Elsinor & Duvall Aves.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME L. KATHARINE TICKNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles M. Tickner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
76	0	10		

9. Birthplace Guldens, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ephriam Miller
13. Birthplace Pa.

MOTHER
14. Maiden Name Susan Showalter
15. Birthplace — Pa.

16 (a) Informant Miss Dorothy Tickner
(b) Address 2809 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 19 1946 (Date rec'd by registrar) Washington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1946 at 1 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1946 to 8-16 1946, and that I last saw her alive on 8-16 1946

Immediate cause of death Uremia — Duration

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Buchanan M. D.
Address West Balto Genl Hosp. Date signed 8-16-46

VS 150

G42968 BALTIMORE CITY HEALTH DEPARTMENT G42968
CERTIFICATE OF DEATH 131a
Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Woodland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1662 Gorsuch Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS NEUBAUER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Louise Neubauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 30, 1859

8. AGE: Years	Months	Days	If less than one day
87	4	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Nicholas Neubauer
13. Birthplace Bavaria

MOTHER
14. Maiden Name Anna Romer
15. Birthplace - Bavaria

16 (a) Informant Mr. John Neubauer
(b) Address 310 Cedarcroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., Md.

AUG 17 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1946, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7- 1946 to Aug 16 1946 and that I last saw h[illegible] alive on Aug 15 1946

Immediate cause of death

Due to Chr. Myocarditis — Duration 1944

Due to Chr. Interstitial nephritis — 1944

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Paul F. Smith
Address 1663 W. North Ave. Date signed 8/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G42969 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE A. GEDDES

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1868

8. AGE: Years	Months	Days	If less than one day
78	2	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name James W. Geddes
13. Birthplace Balto.

MOTHER
14. Maiden Name Sarah A. Hulse
15. Birthplace Balto.

16 (a) Informant Mrs. Daisy Muller
(b) Address 2828 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) AUG 17 1946 (b) (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 19 46, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug 16 1946 and that I last saw h alive on Aug 15 1946.

Immediate cause of death:
Coronary Thrombosis — Duration Todays
Due to Coronary sclerosis — Indefinite
Due to
Other Conditions Generalized Arteriosclerosis Hypertrophic Cirrhosis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Cotter M. D.
Address 11 E. Chase St. Date signed Aug 17 1946

G42970 Neiser G42970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Abingdon
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mattie M. Neiser

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife William Neiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 | 26 | 98

8. AGE: Years	Months	Days	If less than one day
48	6	21	hr. min.

9. Birthplace Baltimore County Md
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name William Burke
13. Birthplace Penna.

MOTHER 14. Maiden Name Mary L. Gordon
15. Birthplace Baltimore Co Md.

16 (a) Informant Frederick Neiser
(b) Address Abingdon, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 | 18 | 46 (month) (day) (year)
(c) Cemetery or crematory Franklinville Presbyterian
Location Franklinville, Balto Co Md.

18 (a) Funeral director Howard H. McComas & Son
(b) Address Abingdon, Md.

19 (a) Filed [illegible] (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1946, at 9.57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1946 to 8/15 1946.
and that I last saw h[illegible] alive on 8/15 1946

Immediate cause of death Cardiac failure — Duration

Due to Carcinoma - probably ovarian Origin

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 7/16/46 - 8/6/46
Major findings of operation: Primary adenocarcinoma tumor noted
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Wells M. D.
Address 16 Jo - Bmg Date signed 8-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G4297 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G4297 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5003 Falls Road Terrace
(c) Hospital or institution: at home —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 FALLS ROAD TERRACE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME JULIET CARTER WOOD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: PETER B. WOOD

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 30 OCTOBER 1892

8. AGE: Years 53 | Months 10 | Days 14 | If less than one day — hr. — min.

9. Birthplace: MIDDLEBURG, LOUDON Co. Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: —

FATHER
12. Name: RICHARD WELBY CARTER
13. Birthplace: LOUDON Co., Va

MOTHER
14. Maiden Name: SOPHIE CARTER
15. Birthplace: FARQUIER Co., Va

16 (a) Informant: HUSBAND – PETER B. WOOD
(b) Address: 5003 FALLS ROAD TERRACE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-46 (month) (day) (year)
(c) Cemetery or crematory: Private Burial Ground
Location: (on farm) near Middleburg, Va.

18 (a) Funeral director: STEWART & MOWER COMPANY
(b) Address: (W. F. MOWER SUC.) 100 W. NORTH AVENUE

19 (a) Filed by registrar AUG 17 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 AUGUST 1946, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 17 AUG 1946 to 17 AUG 1946, and that I last saw D. alive on 17 AUG 1946.

Immediate cause of death: ABDOMINAL CARCINOMATOSIS — Duration: 3 MOS. ?

Due to: CARCINOMA OVARY (BILATERAL)

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: 2 JUNE, 1946

Major findings of operation: (AS ABOVE)

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature: John M. Scott M. D.

Address: 5004 WOOD ROAD Date signed: 17 AUG '46

BALTO 10 ×

G42972
499038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G42972
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. County
(c) City or town Glambrills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Jackson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-17-44.

8. AGE: Years	Months	Days	If less than one day
2	3	-	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Chester Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Virgie Cross
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Reisters.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-46 (month) (day) (year)
(c) Cemetery or crematory Cross
Location Davidsonville Md.

18 (a) Funeral director A. A. Wittke
(b) Address 410 Edmondson Ave Huntington Baltimore, Md.

AUG 17 1946 (b) — Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug- 17 1946 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug- 15 1946 to Aug- 17 1946 and that I last saw him alive on Aug 17 1946.

Immediate cause of death: Tuberculous meningitis — Duration: 2 weeks
Due to
Due to
Other Conditions: tuberculosis pulmonary
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. Randol
Address Johns Hopkins Hospital Date signed 8/17/46

VS 150

(2)

G42973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G42973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 ROLAND AVE.
(c) Hospital or institution: KIRKLEIGH VILLA.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.YEARS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3214 MONTIBELLO TERRACE (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ROSE CORDERY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife late Samuel.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 84 Months Days 3 If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Michael Fongie

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Shields.

15. Birthplace Ireland

16 (a) Informant Joseph Cordery

(b) Address 3141 Montebello Ter

17 (a) (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day or year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director H. Wyatt Lee

(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

AUG 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 15 1946 10.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 21 1946 to AUG 15 1946 and that I last saw her alive on AUG 15 1946

Immediate cause of death	Duration
CHRONIC MYOCARDITIS MAY.21	1946.
Due to ARTERIOR SCLEROSIS.	1946.
Due to	
Other Conditions SENILITY.	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operations NONE

of autopsy: NONE.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas F. Clautice M. D.

Address 5013 ST PAUL ST Date signed AUGUST 16 1946.

CLAUTICE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42974 puer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G42974 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Min. 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore – 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1648 Lombard Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Premature Girl Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F		

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-16-46

8. AGE: Years	Months	Days	If less than one day
		1	4 hr. 15 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Lee Miller
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Jennie Josephine Bistink
15. Birthplace Parsons Penn.

16 (a) Informant Mrs. Freda Mc Gee
(b) Address 29 S. Rosedale St, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 / 18 / 46 (month) (day) (year)

(c) Cemetery or crematory St. John's Cemetery
Location Ellicott City Md.

18 (a) Funeral director Eastern Stone
(b) Address Ellicott City, Md.

AUG 17 1946 (Registrar's signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17- 1946, at 9 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16-1946 to 8-17-1946. and that I last saw h alive on 19

Immediate cause of death	Duration
Due to Premature (28 weeks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. E. Carr M. D.

Address Date signed 8/17/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G42975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G42975 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3433 Old Frederick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3433 Old Frederick Road
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Sterba

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 17, 1872

8. AGE: Years	Months	Days	If less than one day
73	9	-	hr. min.

9. Birthplace Hungary (Town, county, and state or foreign country)

10. Usual Occupation Cabinet Maker

11. Industry or business Retired

FATHER 12. Name Unknown

13. Birthplace Hungary

MOTHER 14. Maiden Name Unknown

15. Birthplace Hungary

16 (a) Informant Dora Beck

(b) Address 3433 Old Frederick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-46 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Howard County, Md.

18 (a) Funeral director Leary & Polchow

(b) Address 2101 Frederick Avenue

AUG 18 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1946 to Aug 17 1946, and that I last saw h[illegible] alive on Aug 16 1946

Immediate cause of death

Due to (Right hemiplegia) Cerebral Hemorrhage — Duration 2/1/46

Due to Chr. Myocarditis — 1944

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Brown M. D.

Address 1663 W. Mount St. Date signed 8/17/46

Huntington Williams M.D. for O. H. B. Hoefnick, by Howard L. Williams, M. D.

G42976 ✓ G42976

BALTIMORE CITY HEALTH DEPARTMENT 1939

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Westernport (If outside city or town limits write RURAL and give town)
(d) Street No. 313 Hammond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Cheshire

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Odie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-83

8. AGE: Years 62 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace Penn (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Clay

13. Birthplace Penn

MOTHER 14. Maiden Name Tibia Dicken

15. Birthplace Penn

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22/46 (month) (day) (year)

(c) Cemetery or crematory

Location Westernport Md

18 (a) Funeral director Geo. D. Ogden

(b) Address 300 E. Balto. St

1946 (b) Date rec'd by registrar

Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 at 9:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Aug 17 1946 and that I last saw her alive on Aug 17 1946

Immediate cause of death: Arteriosclerotic heart disease — Duration: 3 3-5 yrs.

Due to

Due to

Other Conditions Chronic glomerulitis von Recklinghausen's disease

(Include pregnancy within 3 months of death)

Date of operation 8/17/46

Major findings of operation: Ovary skin suspension made

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marshall A. Sanford M. D.

Address John H. Osler Date signed Aug 17/46

G42977. Mattie Metheney G42977.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument + Rutland Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 N Lloyd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Metheney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Albert Wm. Metheney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24 1893

8. AGE: Years 53 Months 4 Days 12 If less than one day hr. min.

9. Birthplace West Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Johnson
13. Birthplace West Va.

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Marion Hartman
(b) Address 422 N. Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-46 (month) (day) (year)
(c) Cemetery or crematory Loch Raven
Location Loch Raven Md.

18 (a) Funeral director John C. Kelly Sons
(b) Address 2435 E. Oliver St

19 (a) (Date received by registrar) (b) Huntington Hillsboro, W. Va.

AUG 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 46, at 7:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 19 46 to Aug 15 19 46
that I last saw her alive on Aug 15 19 46.
Immediate cause of death Cerebro-vascular accident. | Duration
Due to Hypertensive and arterio sclerotic Kid Disease
Due to Chronic pyelonephritis
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reinig Beissinger M.D.
Address Sinai Hospital Date signed 8/19/46

G42978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G42978 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25 S. Curley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE RICHARD HOGG

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. 212-12-5520

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Hogg
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1885

8. AGE: Years	Months	Days	If less than one day
61	0	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Western Electric Co.

FATHER
12. Name Richard Hogg
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Barbara Griesner
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Hogg (Widow)
(b) Address 25 S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-46. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4300 Belair Rd.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait Ave.

19 (a) [illegible] (b) [illegible]
AUG 18 1946
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th 1946 at 12:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1946 to Aug. 15 1946, and that I last saw him alive on Aug. 15 1946.

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation April 1946
Major findings of operation: Carcinoma of Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Brolle M. D.
Address 1331 Shrodes Date signed 8-16-46

X

G42979 ✓ G42979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Schuck St. 26 St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME MARY C. BITTNER

If U. S. Veteran specify WAR

(a) Residence: No. 3302 Schuck St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Conrad Bittner

6. DATE OF BIRTH (month, day, year) Jan. 20, 1873.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
93	76	6	26 27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House-Work

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At home.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME William Ruley

14. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

MOTHER

15. MAIDEN NAME Henrietta ?

16. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

17. INFORMANT (Address) Conrad Bittner (Husband) 3302 Schuck St.

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Mt. Carmel Cem. Date Aug. 20, 46

19. UNDERTAKER (Address) Charles L. Fiele. 3605 Fait Ave.

20. FILED AUG 18 1946 Huntington Williams, M.D. Registrar. Deputy.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug. 16, 1946

22. I HEREBY CERTIFY, That I attended deceased from 1946 to Aug. 16 1946

I last saw her alive on Aug. 16, 1946 Death is said to have occurred on the date stated above, at 1:45 P. m.

The principal cause of death and related causes of importance were as follows:

ARTERIOSCLEROSIS — Duration of each 10 yrs.

CEREBRAL HEMORRHAGE — Aug. 16, 1946

Other contributory causes of importance:

Was an operation performed? NO Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? NONE Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signed) Benjamin Wightstein M. D.

(Address) 1121 S. HIGHLAND AVE.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

394896 G42980

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G42980
Registered No.

CERTIFICATE OF DEATH 46 B

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNPADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Broadway
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 246
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Robert Lee Schuler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary J. Schuler
6 (c) If wife, give age 68 years

7. Birth date of deceased (mo., day, yr.) 8-8-81

8. AGE: Years	Months	Days	If less than one day
65	-	9	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER 12. Name E. R. Schuler
13. Birthplace Va.

MOTHER 14. Maiden Name Elizabeth Parks
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Comers Rock
Location Castle Va

18 (a) Funeral director Laurence F. Hoffman
(b) Address 1639 Broadway

19 (a) AUG 19 1946 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 August 1946, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 August 1946, to 17 August 1946, and that I last saw h[illegible] alive on 17 August 1946

Immediate cause of death	Duration
Broncho-pneumonia	
Due to Cardiac Failure	
Due to Carcinoma of Stomach	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation 13 August 46
Major findings of operations: Carcinoma of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. William Scott, Jr.
Address Johns Hopkins Hospital signed 8/17/46

Houston for Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G42981 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Webb Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Webb Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Cairns

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Retta B. Burnight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1874

8. AGE: Years	Months	Days	If less than one day
71	8	26	hr. min.

9. Birthplace Delaware City Del. (Town, county, and state)
10. Usual Occupation Sta. Engneer
11. Industry or business

FATHER
12. Name John F.
13. Birthplace Penna.

MOTHER
14. Maiden Name Jane Hutchinson
15. Birthplace Penna.

16 (a) Informant Wife
(b) Address 1015 Webb Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) [illegible] Washington Nelson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-46 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 46 to Aug 17 19 46 and that I last saw him alive on Aug 24 19 46

Immediate cause of death Uremia — Duration 6 days

Due to Chronic Nephritis

Due to Chronic Prostatitis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Kate T. [illegible]
Address Stoneboro, Penna. Date signed 8-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 181

G42982

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparks - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Rebekah F. Mitchell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 7, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
55	1	13		

9. Birthplace Sparks, Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Music Teacher
11. Industry or business

FATHER
12. Name Frederick J. Mitchell
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Rebecca Gorsuch
15. Birthplace Balto. Co. Md.

16 (a) Informant Miss Mary Mitchell
(b) Address Sparks Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-46 (month) (day) (year)
(c) Cemetery or crematory Emmanuel
Location Glencoe, Md.

18 (a) Funeral director Loudon & Brooks
(b) Address Sparks, Md.

19 1946 Filed by registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1946 at 7 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17-46 19 to 8-17-46 19; and that I last saw h alive on 8-17-46 19 —

Immediate cause of death Pulmonary embolism — Duration 2 days.

Due to Thrombosis of pelvic and femoral veins

Due to 1st 2nd and 3rd degree burns (self imposed)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-11-46 and 8-15-46

Major findings of operation: Extensive burns

of autopsy: Embolism + Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Aug 17/46 at — M
(c) Where did injury occur? Sparks (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Kerosene burns

23. Signature John F. Rogers M. D.
Address Md Gen Hosp Date signed 8/17

Approved by Howard J. Malone M.D.

G42983

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G42983 Registered No.

CERTIFICATE OF DEATH 91a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life (64 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto, 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Colraine Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Quent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife MARY C

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) MARCH 4 (1879) 1882

8. AGE: Years	Months	Days	If less than one day
64 (67)	5	13	hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation WOOD FINISHER

11. Industry or business JOHN C. KNIPP & SONS

FATHER
12. Name FRANK QUENT
13. Birthplace MARYLAND

MOTHER
14. Maiden Name DOROTHY V. SCHRIEBER
15. Birthplace MARYLAND

16 (a) Informant MRS MARY C. QUENT
(b) Address 609 COLERAINE ROAD

17 (a) BURIAL (b) Date thereof AUG. 20, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST.

(a) Date received (Registrar) (b) Huntington Williams, M.D.

AUG 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 at 6:A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1946 to Aug 17 1946, and that I last saw ~~him~~ alive on Aug 16 1946.

Immediate cause of death Cerebral Embolism — Duration

Due to Acute Bacterial Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard J. Cron M. D.

Address University Hosp Date signed

X 8/17 46

G42984 ZL - 103449 BCH B 38753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

G42984
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 S. Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1945

8. AGE: Years	Months	Days	If less than one day
	7	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Marshall
13. Birthplace Md.

MOTHER
14. Maiden Name Anne Lutrzykowski
15. Birthplace Md.

16 (a) Informant: B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location Germantown Hills Md.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

AUG 19 1946 Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1946 at 8:20a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1946 to Aug. 18 1946 and that I last saw him alive on Aug. 18 1946

Immediate cause of death Meningitis — Duration 3 wks

Due to Ruptured Meningomyelocele — 3 wks

Due to

Other Conditions Hydrocephalus — 7 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin, M. D.
Address Baltimore City Hospitals Date signed Aug 18 1946

G42985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93a

G42985 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 276 S London ave
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 276 S Londonave
(If rural give location)
(e) Citizen of foreign country? V (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C Lenze

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Robert Lenze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1871

8. AGE: Years	Months	Days	If less than one day
74	9	19	hr. min.

9. Birthplace Maryland (State, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name John Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Stover
15. Birthplace Maryland

16 (a) Informant Thomas Lenze
(b) Address 276 S Londonave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory Londonpark
Location Balto City

18 (a) Funeral director Tobin & MacNabb
(b) Address Catonsville Md

AUG 19 1946

(b) Registrar Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5 1946 to 8-15 1946 and that I last saw h[illegible] alive on 8-15 1946.

Immediate cause of death: Acute Myocarditis — Duration ½ yr.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Lloyd Johnson M. D.
Address Catonsville Md Date signed 5-17-46

X

G42986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G42986
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dist.
(c) Hospital or institution: Providence Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1805 Little Wash St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Harry Chiles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Sarah Chiles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/[illegible]/80

8. AGE: Years	Months	Days	If less than one day
65	11		hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Wm. H Chiles
13. Birthplace Richmond Va

MOTHER
14. Maiden Name Louisa Brown
15. Birthplace Richmond Va

16 (a) Informant James H. Chiles
(b) Address 608 Hancock St. Richmond Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22. 1946 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location Richmond Va.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave Huntington Williams Md

AUG 19 1946
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1946, at 6[illegible] P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Tutwiler M.D.
Medical Examiner.
Date signed 8/18/46

G42987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G42987 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.H.
(b) Street address 2029 Eutaw Place
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence O. Dix

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Adelaide Brooke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1888

8. AGE: Years	Months	Days	If less than one day
58	✓	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Wm. Dix
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Gaither
15. Birthplace ✓

16 (a) Informant Mrs. Adelaide B. Dix
(b) Address 2029 Eutaw Pl.

17 (a) Burial (b) Date thereof 8/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

AUG 19 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1946 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/16/46

VS 151

G42988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G42988 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 2nd St & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Longwood Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Steele Hooper Waters

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1861

8. AGE: Years	Months	Days	If less than one day
85	3	27	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr Henry Hooper
13. Birthplace Md

MOTHER
14. Maiden Name Louisa Steele
15. Birthplace Md

16 (a) Informant Mrs R. Faulkner (daughter)
(b) Address 204 Longwood Road, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemy.
Location Frd. Ave, Balto. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

AUG 19 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1946, at 6:37 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1946, to 8-18 1946, and that I last saw h alive on 19

Immediate cause of death: Intestinal obstruction — Duration 6 mos

Due to Carcinoma of ovary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-14-46

Major findings of operation: Ca of ovary
Intestinal obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice D. Lieber M.D.
Address Union Memorial Hosp. Date signed 18 Aug 46

M Lieber

G42989

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

G42989
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Johns Hopkins Hospital 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Spring Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph Georg Edward (Smith) Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Unknown.

6 (b) Name of husband or wife Unknown.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 1866

8. AGE: Years	Months	Days	If less than one day
79	7	23	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Katherine Frederick
(b) Address 603 Sussex Rd. Towson

17 (a) Burial (b) Date thereof 8/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill.
Location Annapolis Rd.

18 (a) Funeral director John D Connelly.
(b) Address 416 Eastern ave Balto 21

19 AUG 19 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1946, at 11 A M

21. I certify that I took charge of the remains described above, held an INSPECTION thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-16-46

VS 151

G42990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G42990

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE
(c) Hospital or institution: CONVALESENCE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 MONTHS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4819 LAUREL AVE.
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Catherine Kirwan

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter Kirwan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1860

8. AGE: Years	Months	Days	If less than one day
86	3	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John M. Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Waldner
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Walter Kirwan
(b) Address 4819 Laurel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves. Balto. Md.

AUG 19 1946 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 16 1946 at 7.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 8 1946 to AUG 16 1946 and that I last saw her alive on AUG 16 1946

Immediate cause of death	Duration
CHRONIC MYOCARDITIS APRIL 8	1946
Due to ARTERIOR SCLEROSIS	1946
Due to SENILITY.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in case of place)
(e) Means of injury

23. Signature Chas. P. Edmunds M. D.
Address 3013 ST PAUL ST Date signed AUGUST 16 1946

G42991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G42991 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 5
(e) Length of stay in Baltimore (~~yrs., mos.~~, or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County —
(c) City or town Buchanan (If outside city or town limits, write RURAL and give town)
(d) Street No. —
(e) Citizen of foreign country? (If rural give location) No. (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Franklin Edgell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Earl F. Edgell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1893

8. AGE: Years	Months	Days	If less than one day
53	0	8	hr. min.

9. Birthplace Buchanan, W. Va. (Town, county, and state)
10. Usual Occupation Garage owner
11. Industry or business

FATHER
12. Name Rev. Eugene Edgell
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah Jackson
15. Birthplace West Virginia

16 (a) Informant Mrs. Earl Franklin Edgell
(b) Address Buchanan, W. Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8 19 46 (month) (day) (year)
(c) Cemetery or crematory
Location Buchanan W. Va.

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St

AUG 19 1946 (b) Huntington W. Va.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1946, at 1:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19, 1946 to Aug. 19, 1946 and that I last saw h~~er~~ alive on Aug. 19, 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Cardiac failure	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul B Tomes
Address 33rd & Calvert Sts. Date signed 8/19/46

G42992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

G42992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Eaton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Co (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Brunswick St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas H Dehoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If wife, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 9th 1899

8. AGE: Years	Months	Days	If less than one day
46	11	8	— hr. — min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Tobacco Leaf

FATHER 12. Name August Dehoff

13. Birthplace Washington, D.C.

MOTHER 14. Maiden Name Margaret Kaiser

15. Birthplace Maryland

16 (a) Informant Aug Dehoff

(b) Address 711 Rockwell Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Aug 20 1946 (month) (day) (year)

(c) Cemetery or crematory Geo Lawrence

Location Baltimore Md

18 (a) Funeral director J A Kirkpatrick Son

(b) Address 300 Eutaw Place

AUG 19 1946 (Date rec'd by registrar) (b) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1946, at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1946 to 8-17 1946 and that I last saw him alive on 8-17 1946

Immediate cause of death: Cardiac failure — Duration

Due to Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 15, 1946

Major findings of operation Hemorrhage from Colon + stomach, bleeding from gall bladder bed

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel Hope Jr. M.D.

Address St Agnes Hospital Date signed 8/19/46

G42993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G42993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert ST.
(c) Hospital or institution: Union Memorial Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 John Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Tillman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Mrs. George Tillman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1881

8. AGE: Years	Months	Days	If less than one day
65	4	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Gas & Electric
11. Industry or business

FATHER
12. Name George Thomas Tillman.
13. Birthplace ?

MOTHER
14. Maiden Name Mattie Killamn.
15. Birthplace ?

16 (a) Informant Mrs. Georgia Tillman
(b) Address 1426 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. F. Evans-Son
(b) Address 118 W Mt Royal Ave

AUG 19 1946 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1946, at 7:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1946 to Aug. 16 1946, and that I last saw him alive on Aug 16 1946.

Immediate cause of death	Duration
Pulmonary Edema	30 hours
Due to Myocardial infarct	4 days
Due to Arteriosclerotic Heart disease	Unk
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Mem. Hosp. Date signed Aug 14

VS 150

G42994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G42994

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 N Ellen
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH BOSTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Buddy Boston

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct 5 1894

8. AGE: Years	Months	Days	If less than one day
51 5Y	10	11	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alexander Hilton

13. Birthplace Baltimore - Md.

MOTHER 14. Maiden Name Sallie Scott

15. Birthplace Baltimore - Md.

16 (a) Informant Elizabeth Kirby

(b) Address 502 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Baltimore, Md.

18 (a) Funeral director Mrs Dola Bailey

(b) Address 1421 E. Jefferson St.

(c) Licensed Undertaker Huntington Williams, M.D.

AUG 19 1946

Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16/46 19 . at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma, generalized
primary origin undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 8/16/46

G42995 BCH

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G42995

F27333 CERTIFICATE OF DEATH 54a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 392 Route 13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Fred Koester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-28-41

8. AGE: Years	Months	Days	If less than one day
5	3	19	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name August Koester
13. Birthplace Md

MOTHER
14. Maiden Name Emma Heck
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Lucerne -

17 (a) Burial (b) Date thereof Aug. 19-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bethlehem Lutheran
Location Eastern Ave.

18 (a) Funeral director John F. Mills
(b) Address 2334 Jefferson St.

19 AUG 19 1946 Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1946 at 10 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug 16 1946 and that I last saw him alive on Aug 16 1946.

Immediate cause of death Cerebellar tumor — Duration 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature C. L. Bondurant
Address Johns Hopkins Hosp. Date signed 8/19/46

VS 150

X

G42996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G42996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1220 W. Ostend St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 W. Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Hadaway

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Lydia E. Brown
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1864

8. AGE: Years	Months	Days	If less than one day
82	6	1	hr. min.

9. Birthplace Chestertown, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B.& O. R.R.

FATHER
12. Name George Hadaway
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Elizabeth Ashley
15. Birthplace Chestertown, Md.

16 (a) Informant Mrs Sadie Murphy
(b) Address 1203 Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Hedgerich & Hole
(b) Address 1600 W. Lombard St.

AUG 19 1946 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 16th 1946, at 7:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to August 16 1946, and that I last saw him alive on 8-16-1946

Immediate cause of death: Terminal Bronchopneumonia
Due to Arteriosclerosis - generalized
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 5+yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo Lamb M.D.
Address 642 N. Eutaw St. Date signed 8-19-46

Dr. Dunnigan

G12997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G12997.
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4705 Pilgrim Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4705 Pilgrim Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Robert Ford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Wilma Grace Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1911

8. AGE: Years	Months	Days	If less than one day
35	3	27	hr. min.

9. Birthplace Rochester N.Y.
(Town, county, and state)
10. Usual Occupation Glenn L. Martins
11. Industry or business

FATHER
12. Name Earle Ford
13. Birthplace N.Y.

MOTHER
14. Maiden Name Cora ?
15. Birthplace N.Y.

16 (a) Informant Mrs. Willma G. Ford
(b) Address 4705 Pilgrim Road.14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Mount Zion
Location Bel Air, Md.

18 (a) Funeral director Leonard J. Ruck
(b) 5305 Harford Road.14

19 (a) AUG 19 1946 (Date rec'd by registrar) (b) Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1946 to 8/18 1946, and that I last saw h[illegible] alive on 8/18 1946.

Immediate cause of death
Intestinal Obstruction and metastases
Due to Carcinoma of the ascending colon
Due to
Other Conditions Fecal fistula
(Include pregnancy within 3 months of death)

Duration
6 mos.
months

Date of operation 2/19/46 and 4/17/46
Major findings of operation: Carcinoma of ascending colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Dunnigan M. D.
Address 31 E. North ave Date signed 8/18/46

VS 190

X

G12998 — B.C.I.-54864 — G42998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161c — Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert Street
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Fourth Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kerr — Richard Kerr
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/12/46
8. AGE: Years | Months | Days 4 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation child
11. Industry or business

MOTHER / FATHER
12. Name Richard W. Kerr
13. Birthplace Detroit, Mich.
14. Maiden Name Spooltra, Alice
15. Birthplace Chicago, Ill

16 (a) Informant James J. Wilson M.D
(b) Address Mercy Hospital, Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road. 14

19 AUG 19 1946 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1946 to 8/16 1946 and that I last saw him alive on 8/16 1946.

Immediate cause of death Erythroblastosis Fetalis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Wilson
Address Mercy Hospital, Balt Date signed 8/16/46

VS 150

2999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G42999 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6209 Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6209 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Schuman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	widow

6 (b) Name of husband or wife Adam Schuman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27 1862

8. AGE: Years	Months	Days	If less than one day
84	4	20	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Beynon
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Richards
15. Birthplace Wales

16 (a) Informant: Chas Schumann
(b) Address 3017 Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto Md

18 (a) Funeral director Wm H Hunt Funeral Home
(b) Address 2008 Orleans St

(c) Date received by registrar AUG 19 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946, at 2 80 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1946 to Aug. 17 1946, and that I last saw h[er] alive on Aug 17 1946.

Immediate cause of death: Arteriosclerotic Cardio-vascular disease. — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J Schmitz M. D.
Address 701 N. Howard St. Date signed Aug 17-46

VS 150

643000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

643000 Registered No.

Write the cause of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 7106 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth A. Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Married

6 (b) Name of husband or wife Richard G Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 1882

8. AGE: Years	Months	Days	If less than one day
64	6	28	hr. min.

9. Birthplace Balto (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fred Baumgartner
13. Birthplace Md

MOTHER
14. Maiden Name Mary Gruethen
15. Birthplace Md

16 (a) Informant Richard G Bauer
(b) Address 7106 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 2008 Orleans

19 AUG 19 1946 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1946 at 8 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 2 1946 to August 16 1946 and that I last saw h[illegible] alive on August 18 1946

Immediate cause of death: Cardiac Collapse — Duration

Due to Cardiac Decompensation

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maynard Legard M. D.
Address Maryland General Hospital Date signed 8-19-46

VS 150

95c

G43001

BALTIMORE HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G43001

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B.C. Co.
(c) City or town Arnold.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Rusk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Martha Rusk

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 11-13-97.

8. AGE: Years 48 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Carpenter - Painter

11. Industry or business

FATHER 12. Name Edward Rusk

13. Birthplace Md.

MOTHER 14. Maiden Name Sally Johnson

15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1946 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery

Location Woodlawn, Md.

18 (a) Funeral director E. Willis Lamoreau

(b) Address 1005 W. Baltimore St.

AUG 19 1946 (Date received by registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8.16 1946 at 10 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1946 to 8.16 1946 and that I last saw h.. alive on 8.16 1946.

Immediate cause of death Cerebral hemorrhage?

Due to Hypoprothrombinemia

Due to Liver damage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Negley M. D.

Address Johns Hopkins Hosp. Date signed 8-16-46

G43002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G43002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 Bowers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Bowers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Kornmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Lewis Kornmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 19, 1862

8. AGE: Years	Months	Days	If less than one day
83	9	28	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Jacob Seiler
13. Birthplace Germany

MOTHER
14. Maiden Name Justina Sackman
15. Birthplace Germany

16 (a) Informant Mrs. Mark Z. Bishop
(b) Address 2906 Bowers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 AUG 19 1946 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 August 1946, at 4:44 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio-Vascular Renal Disease
Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 17 Aug. 1946

G43003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 1486

G43003 Registered No. 2698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Whatcoat St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) over 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Whatcoat St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie McNeill 5046, 5047

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Harry McNeill
6 (c) If alive, give age 26 years
7. Birth date of deceased (mo., day, yr.) June 15 1921
8. AGE: Years 25 | Months 2 | Days 1 | If less than one day hr. min.
9. Birthplace Portsmouth Va (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business own home

FATHER
12. Name Unknown
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Harry McNeill
(b) Address 1221 Whatcoat St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pennsylvania Ave
(a) Date received by registrar AUG 19 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16-1946, at 10:10 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 8-15-1946, to 8-16-1946, and that I last saw her alive on 8-16-1946.

Immediate cause of death: Acute Nephritis — Duration 48 days
Due to probably to pregnancy — 7 days
Due to — over
Other Conditions Acute bronchitis — 3 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank L. Saunders M. D.
Address 1029 N. Stricker St Date signed 8-16-46

X

G43004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 43a

G43004 Registered No.

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Coates
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	W

6 (b) Name of husband or wife a.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days.	If less than one day
66			hr. min.

9. Birthplace A. A. Co. Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Coates
13. Birthplace A. A. Co. Md

MOTHER
14. Maiden Name Gaya gona
15. Birthplace Md.

16 (a) Informant Mary Collins
(b) Address 1807 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Lubulus
Location Md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) AUG 19 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1946, at 4 P M

21. I certify that death occurred on the date above named; that I attended deceased from 7/14 1946 to 8/15 1946.
and that I last saw him alive on 8/13 1946

Immediate cause of death Cerebral apoplexy

Due to Paralysis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 8/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G43005

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4024 Massachusettes Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Mass. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Vollmer,

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rosa Vollmer,
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 26, 1874

8. AGE: Years	Months	Days	If less than one day
72	0	21	hr. min.

9. Birthplace Hungary, (Town, county, and state)
10. Usual Occupation Grocer,
11. Industry or business

FATHER
12. Name Ludwig Vollmer,
13. Birthplace Hungary,

MOTHER
14. Maiden Name Maria A. Zollmer,
15. Birthplace Hungary,

16 (a) Informant Mr. Wendel A. Vollmer,
(b) Address 4024 Mass. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park,
Location Baltimore City,

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.
(c) (Date received by registrar) AUG 19 1946 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1946 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9/ 1946 to 8/17/ 1946. and that I last saw him alive on 8/16. 1946.

	Duration
Immediate cause of death Endarteritis obliterans, general and cerebral arterio sclerosis.	3 mos. 8 days
Due to	
Due to	
Other Conditions Gangrene right foot. (Include pregnancy within 3 months of death)	2 mos.

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weibel M. D.
Address 1226 Hanover St. Date signed 8/19/1946.

X

G43006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

G43006 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Lemmon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Titus Garrett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1915

8. AGE: Years	Months	Days	If less than one day
31	1	9	hr. min.

9. Birthplace Essex Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert Lee Carter
13. Birthplace Va

MOTHER
14. Maiden Name Flossie Simons
15. Birthplace Va

16 (a) Informant Lucille Woodley
(b) Address 935 Parrish St

17 (a) Burial (b) Date thereof Aug. 19 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 922 N. Schroeder St.

AUG 19 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1946, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Insp & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Mitchell M.D.
Medical Examiner
Date signed 16 Aug 46

G43007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G43007 Registered No. 3698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1044 Stockton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 Stockton (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Squire Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1861

8. AGE: Years	Months	Days	If less than one day
85	6	3	hr. min.

9. Birthplace Kent Queens Co Va (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Hubert Sydnor
(b) Address 1044 Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie K. Williams
(b) Address 3229 W. Schroeder St.

19 Aug 19 1946 Date received by Registrar Huntingtown Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1946, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1946, to 8-15- 1946, and that I last saw alive on 8-15 1946.

Immediate cause of death	Duration
Carcinoma of prostate	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1054 N. Stricker St Date signed 8-16-46

VS 150

X

G43008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G43008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RAL and give town)
(d) Street No. 1134 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Woody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife Dennis Woody
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1884

8. AGE: Years	Months	Days	If less than one day
62	7		hr. min.

9. Birthplace Westmoreland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Campbell
13. Birthplace Va.

MOTHER
14. Maiden Name Katie
15. Birthplace Va.

16 (a) Informant Dennis Woody
(b) Address 1134 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 822 W. Schroeder St.

AUG 19 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1946 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1946 to Aug 14 1946 and that I last saw her alive on Aug 14, 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Hypertension Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Howell
Address 601 N. Carrollton Ave. Date signed 8/16/46

Physician

643009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

643009 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 69 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Sun St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-1893

8. AGE: Years 53 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Twiggs County Ga. (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER 12. Name Dave Hill

13. Birthplace Ga

MOTHER 14. Maiden Name Rachael Mingo

15. Birthplace Ga

16 (a) Informant John Cornelius

(b) Address 1030 N. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location A.A. County, Md.

18 (a) Funeral director Charles H. Harper

(b) Address 510-512 Carrollton Ave.

(c) Address of registrar Huntington Williams, M.D.

AUG 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16th 1946, at 9 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1946 to Aug 15 1946, and that I last saw him alive on Aug 15 1946.

Immediate cause of death: Cardiac Failure — Duration

Due to Pulmonary Emphysema

Due to Arterio selerotic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L.J. Banfield

Address Provident Hosp. Date signed 8/16/46 M. D.

VS 150

G43010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4221. Stanwoodare
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4221. Stanwoodare (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles. Geiger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mary S. Geiger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7. 71

8. AGE: Years 70. | Months 10 | Days 9. | If less than one day hr. min.

9. Birthplace Baltimore Md. (town, county, and state)

10. Usual Occupation Laborer.
11. Industry or business Stevenson Co.

MOTHER / FATHER
12. Name Charles. Geiger
13. Birthplace Baltimore
14. Maiden Name Muhlhouse
15. Birthplace Germany

16 (a) Informant Mary. S. Geiger
(b) Address 4221 Stanwoodare

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave

18 (a) Funeral director Mitchell & Lippel
(b) Address 3125. Highland Ave

19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15. 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to August 1946.
and that I last saw h alive on August 12 1946.

Immediate cause of death Cerebral hemorrhage

Due to H J pertension

Due to

Other Conditions H J pertension Heart
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Oneyear
6 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Kare Trumpt M. D.
Address Lombard & Hart Date signed 8-17-46

AUG 19 1946

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G43011 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3942 Bel View ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3942 Bel View ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha Macks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julius H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1900

8. AGE: Years 46 | Months 5 | Days 32 | If less than one day: hr. min.

9. Birthplace Altoona Pa (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Abraham Abelson
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Julius Macks
(b) Address 3942 Bel View ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 360° E Balto st.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave

19 (a) (b) Registrar

AUG 19 1946

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946 at 5:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1946 to 8/19 1946, and that I last saw h[illegible] alive on 8/19 1946.

Immediate cause of death
Massive Cerebral Hemorrhage — Duration 4 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Lubin M.D.

Address 920 Park ave Date signed 8/19/46

For S. K. Davis, by Thomas J. MacAfee, M.D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43012 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 E. Chase Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 E. Chase Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Geisel

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Annie Muller

6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) March 19th, 1864

8. AGE: Years 82 | Months 4 | Days 29 | If less than one day: [illegible] Hr. [illegible] min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Cabinet maker

FATHER
12. Name John Geisel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Charles Geisel (son)
(b) Address 1628 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Date received by registrar AUG 19 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18th 1946 at 2a M

21. I certify that death occurred on the date above stated, that I attended deceased from June 10 1946 to Aug 18 1946.
and that I last saw h[illegible] alive on Augs 17 1946

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: 10 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith M. D.
Address 1223 E. North Date signed 8/19/46

G43013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 937

G43013
Registered No.

MARGIN RESERVED FOR BINDING — Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 Windsor Ave.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 15
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Emma Louisa Stern

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 3 1856

8. AGE: Years 89 | Months 8 | Days 15 | If less than one day: hr. min.

9. Birthplace New York State (town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Nicholas Stern
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Rittman
15. Birthplace Stamburg N.Y.

16 (a) Informant N. R. Stern (Bro.)
(b) Address 2917 Windsor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-46 (month) (day) (year)
(c) Cemetery or crematory Prospect Lawn
Location Hamburg N.Y.

18 (a) Funeral director Stewart Mort. Co.
(b) Address 108 W North Ave.

AUG 19 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/46 19 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from about 1930 to 8/18 1946 and that I last saw h[illegible] alive on 8/18 1946.

Immediate cause of death: Cerebral Hemorrhage
Duration: 3 days

Due to: Senility

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Jack R. Morgan M.D.
Address 6 E. Read St. Date signed 8/19/46

G43014 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G43014

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N Caroline St.

(c) Hospital or institution: St Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4516 Maunsell Ave.

(If rural give location)

(e) Citizen of foreign country? Yes, (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Chlumecky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/16/46

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Anthony Chlumecky

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary A. Faus

15. Birthplace Gutenberg, N.J.

16 (a) Informant: Mother

(b) Address 4516 Maunsell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Belgian Road

18 (a) Funeral director Chas. E. Schimpeler

(b) Address 1400 N. Madison Street.

AUG 19 1946 (Date rec'd by registrar) (b) Huntington Station, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1946 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1946 to 8/17 1946, and that I last saw h[illegible] alive on 8/17 1946.

Immediate cause of death Cardio respiratory failure

Due to Prematurity

Due to 2 lbs 13½ oz.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Irving D. Wilson, Jr M. D.

Address St Joseph's Hosp Date signed 18 Aug 46

VS 150

G43015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93a

G43015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 N. Caroline
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hours.

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 Sherman Ave. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Real L. Powers
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced M
6 (b) Name of husband or wife Lillian Powers
6 (c) If alive, give age 50? years

7. Birth date of deceased (mo., day, yr.) — — 1896

8. AGE: Years 50? | Months - | Days - | If less than one day hr. min.

9. Birthplace Kansas City - Mo. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business U.S. Printing office

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Nellie Johnson
(b) Address 1313 N. Caroline

17 (a) (Burial, cremation, or removal) (b) Date thereof 8/19/46 (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] D C

18 (a) Funeral director Robert F. McGuire
(b) Address 9th & Westminster Sts. N.W. D.C.

AUG 19 1946 Registered by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17, 1946 to Aug 17 1946 and that I last saw h[illegible] alive on Aug. 17 1946.

Immediate cause of death	Duration
Acute Myocarditis	5 min.
Due to Cerebral Apoplexy	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Ray Berry M. D.
Address 1420 T. Chas Date signed Aug 19 '46

of J.R. Davis by Howard N. Mackey M.D.

G43016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43016 Registered No.

93E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1977 Biltmore St. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1902

8. AGE: Years 43 | Months 7 | Days 21/20 | If less than one day hr. min.

9. Birthplace Batesburg, S.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Levi Wise
13. Birthplace S.C.

MOTHER
14. Maiden Name Nellie Wise
15. Birthplace S.C.

16 (a) Informant Mrs. Nellie Sullivan
(b) Address 1977 Biltmore St. Washington D.C.

17 (a) Removal (Burial, cremation or removal) (b) Date thereof 8-19-46 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Batesburg S.C.

18 (a) Funeral director Wilhelmina B. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) Washington D.C. (City or town) (State)

AUG 19 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1946, at 1a.m. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure
Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner
Date signed 8-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94B

G43017 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Woodland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Woodland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Grace Dudderar

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Walter B
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1876

8. AGE: Years	Months	Days	If less than one day
69	10	6	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name [redacted]
13. Birthplace [redacted]

MOTHER 14. Maiden Name [redacted]
15. Birthplace [redacted]

16 (a) Informant Charles M. Dudderar
(b) Address 2923 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location E. End of North Ave

18 (a) Funeral director John B. Henry Inc
(b) Address 718 Light St.

19 (a) Filed 1946 (b) by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1946, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1946 to Aug 16 1946. and that I last saw h[illegible] alive on Aug 16 1946.

Immediate cause of death	Duration
Angina Pectoris	[illegible]
Due to	?
Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur D Bulcert M. D.
Address 803 Park Heights Ave Date signed 8/17/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§ 3a

G43018
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 West Lee St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 West Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eliza Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 22, 1887

8. AGE: Years	Months	Days	If less than one day
58	9	20	hr. min.

9. Birthplace Church Creek Maryland
(Town, county, state or foreign country)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Thomas Montgomery

13. Birthplace Church Creek Maryland

MOTHER 14. Maiden Name Annie Stylers

15. Birthplace Church Creek Maryland

16 (a) Informant Margaret Kirk (Sister)

(b) Address Cambridge Mayland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21, 1946 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn

Location Baltimore City

18 (a) Funeral director Joseph A Bailey

(b) Address 6 West Lanvale St

19 (a) Date received by registrar AUG 19 1946 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1946 at 5:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1946 to Aug 17 1946 and that I last saw h[illegible] alive on Aug. 16 1946

Immediate cause of death Cerebral Hemorrhage — Duration 11 days

Due to Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Johnnie W. Gaines M. D.

Address 502 E. Hamburg St Date signed 8/19/46

X

G43019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43019 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calhoun & Fayette Streets

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)

(d) Street No. 321 N. PAYSON ST. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME J.F. William Stissel

3 (b) If veteran, name war	3 (c) Social Security Account No.
UNKNOWN	UNKNOWN

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNIE STISSEL

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) APRIL 15, 1872

8. AGE: Years	Months	Days	If less than one day
74	4	3	hr min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER

12. Name FREDERICK STISSEL

13. Birthplace GERMANY

MOTHER

14. Maiden Name CATHERINE LENTZ

15. Birthplace BALTIMORE Co. MD

16 (a) Informant ANNIE STISSEL

(b) Address 321 N PAYSON STREET

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Balto Md

18 (a) Funeral director Lanahan Funeral Home

(b) Address 7401 Belair Rd Balto 6 Md

19 (a) AUG 19 1946 (b) Received by registrar Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1946, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 15 1946, to August 18 1946, and that I last saw him alive on August 18 1946.

Immediate cause of death	Duration
CARDIAC DECOMPENSATION	
Arteriosclerotic Heart Disease	
Auricular Fibrillation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address Franklin Sq Hosp Date signed 8/18/46

G43020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43020 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2032
(c) Hospital or institution: John Hopkins Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State -1- (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lanicwski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of [redacted] wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1882

8. AGE: Years 64 Months 2 Days 17 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Lanicwski
13. Birthplace Poland

MOTHER
14. Maiden Name Isabella Lebowicz
15. Birthplace Poland

16 (a) Informant Mrs. Anna Lanicwski
(b) Address 2032 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester St.

19 (a) (b) Registrar
(Delayed) registration AUG 24 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1946, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arterio-Sclerotic CV disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Sulinski M.D.
Medical Examiner
Date signed 8/18/46

G43021 BC# B53433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G43021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL or

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Lamont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mc Kittrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-46

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace Md - (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Luther Mc Kittrick
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Prentice
15. Birthplace Md.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 20 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1946 at 10 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1946 to 8-14 1946 and that I last saw h alive on Aug. 14 1946

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Sheldon

Address Date signed 8/19/46

VS 150

G43022

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-86515 — 83a — Registered No. G43022

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals — 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs-9mOs-14days
(e) Length of stay in Baltimore (yrs., mos., or days) 81yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) — 22
(d) Street No. 850 Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Margaret Allman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Adam (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22- 1863

8. AGE: Years 82 | Months 0 | Days 19 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Conrad Vollmuller (D
13. Birthplace Germany

MOTHER — 14. Maiden Name Barbara Ruckle
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address
AUG 20 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 46 at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-43 19 to 8-9- 19 46, and that I last saw h 9F alive on 8-9- 19 46.

Immediate cause of death: Cerebro - vascular accident. — Duration

Due to Generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosp Date signed 8-9-46

VS 150

G43023

B.C.D-61549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159 ✓

G43023
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Greene & Redwood Sts.
(b) Street address ~~246 Meadow Rd~~
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Born 8 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore None
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 246 Meadow Rd
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Talbert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-11-46

8. AGE: Years	Months	Days	If less than one day
0	0	0	8 hr. — min.

9. Birthplace University Hosp. Balto, Md.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Emery Raymond Talbert

13. Birthplace Friendly, Md

MOTHER 14. Maiden Name Mary Gladys Himes

15. Birthplace Baltimore, Md

16 (a) Informant Mary Talbert

(b) Address Same

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School AUG 19 1946

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 20 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1946, at 2 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6:30 AM Aug 11 to 2:30 PM 8-11-46 and that I last saw him alive on Aug 11 1946.

Immediate cause of death	Duration
Pulmonary Atelectasis	
Due to prematurity	
Due to premature labor.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Delivery 8-11-46

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gary K. Driggs, M.D.
M. D.

Address Univ. Hosp. Date signed 8/12/46

X

G43024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 ✓

Registered No. G43024

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hosp.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Eagle St (If rural give location)
(e) Citizen of foreign country? Eager (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Slater Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Esther Slater

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1875

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Slater
13. Birthplace Balto.

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John E. Slater Jr.
(b) Address 1422 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 21 46 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 905 E. Biddle St

19 (a) (Date rec'd by registrar) (b) Washington Williams (Registrar)

AUG 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 to Aug. 7th 1946. and that I last saw h[illegible] alive on Aug. 7th 1946

Immediate cause of death Thrombosis Coronary — Duration couple of years.

Due to arteriosclerosis and hypertension

Due to Myodegeneration

Other conditions Chronic myocarditis of heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Traugott M. D.
Address 1623 E. N. Avenue Date signed 8-19-46

G43025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G43025

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Edwood & Greene Sts

(c) Hospital or institution: University Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 605 N. Carey St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Duggan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B.	M.

6 (b) Name of husband or wife Joseph Duggan

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 11-2-1910

8. AGE: Years	Months	Days	If less than one day
35 36	9	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Williams

13. Birthplace Va

MOTHER 14. Maiden Name Elizabeth Ransen

15. Birthplace Va

16 (a) Informant Ruth Duggan

(b) Address 605 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-46 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Balto. Co.

18 (a) Funeral director Samuel W. Chase & Son

(b) Address 638 N. Eutaw St.

19 (a) (b)

AUG 20 1946

Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/46 19 at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1946 to Aug 18 1946 and that I last saw h- alive on 8/18/46

Immediate cause of death	Duration
(a) Cardiac Dilatation	
Failure	
Due to (b) Aortic Embolism	
Cardiac Thrombosis	
Due to (c) Malignant Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Medical Treatment

of autopsy Laboratory Investigations

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

73. Signature Joseph L. Nicholas M. D.

Address University Hosp Date signed 8/19/46

X

G43026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131R

Registered No. G43026

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Shirley Ave
(c) Hospital or institution: Mt Carmel Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Shirley Ave 2476 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Stern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 Months Days If less than one day hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Abraham

13. Birthplace Russia

MOTHER 14. Maiden Name Mollie

15. Birthplace Russia.

16 (a) Informant Louis Stern

(b) Address 888 Wash. Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Ferguson Hgts Rd.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Baltimore St.

AUG 20 1946 Huntington Williams (Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19-46 19 , at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 19 46, to 8-19 19 46 and that I last saw h alive on 8-19 19 46.

Immediate cause of death Myocarditis
with hypostasis
& pneumonia
Due to Myocarditis

Due to

Other Conditions Glomerulitis
with nephritis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: yes

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Abraham Schapiro M. D.

Address 2028 Eutaw Place Date signed 8/19/46

VS 190

93E

G43027.
CHK-100504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G43027.
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6m 6d
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 1210 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Langston Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29-1915

8. AGE: Years	Months	Days	If less than one day
30	9	17	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Virginia

MOTHER
14. Maiden Name Lottie
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 8-20-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 211 N. Arlington Ave

19 (a) (b)
(Signature of local registrar) (Address)
AUG 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1946 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1946 to Aug. 16 1946, and that I last saw him alive on Aug. 16 1946.

Immediate cause of death Undetermined — Duration

Due to

Due to over

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy Pulmonary fibrosis, bilat.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary E. McMillan M. D.
Address City Hospitals Date signed 8/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No. G43028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Jefferson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY Gibson CUTCHMBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Widowed

6 (b) Name of husband or wife BENJ.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 - 8 - 1883

8. AGE: Years	Months	Days	If less than one day
63	7	9	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation House wife.
11. Industry or business

FATHER
12. Name Wm. H. CUTchmber
13. Birthplace Md.

MOTHER
14. Maiden Name ELLEN ?
15. Birthplace Md.

16 (a) Informant ELLEN Rodgers
(b) Address 1616 Jefferson. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel County, Md

18 (a) Funeral director Joseph G. Lock
(b) Address 1364 N. Central Ave

19 AUG 20 1946 (b) Registrar
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1946, at 3 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to Aug 17 1946 and that I last saw h[illegible] alive on Aug 13 1946.

Immediate cause of death	Duration
Leukemia	3-days
Due to Chronic Nephritis	1-yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert C. Burwell M.D.
Address 1711 Eutaw St W Date signed 8-19-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13029
AB-103545

BC# B48336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. G13029

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Carson Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30- 1946

8. AGE: Years	Months	Days	If less than one day
	2	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Haines
13. Birthplace Md.

MOTHER
14. Maiden Name Dorothy Brown
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

19 AUG 20 1946 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7- 1946, to 8-17 1946.
and that I last saw h im alive on 8-17 1946.

Immediate cause of death Myocardial failure,
Cause unknown
pulmonary edema
Due to Diarrhea
Due to Malnutrition
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Aug 19 '46

X

G43030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43030 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 Bruce Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Bruce Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Richard Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Robert [illegible]
13. Birthplace Md.

MOTHER
14. Maiden Name Kittie [illegible]
15. Birthplace Md

16 (a) Informant John H Dorsey
(b) Address 1115 Stockston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Rices Town, Md.
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

19 AUG 20 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1946, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 18 1946, and that I last saw her alive on Aug 18 1946.

	Duration
Immediate cause of death Cardio Vascular Disease	1 yr.
Due to Broken Compensation	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. William Gray, M.D.
Address 1428 Penna Ave Date signed 8/20/46

G43031
JL - 90768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43031
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y 8m 26d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Bedford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1895

8. AGE: Years	Months	Days	If less than one day
51	6	19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Laura
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Preastman St

AUG 20 1946 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1946 at 10:30 pm

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1944 to Aug. 16 1946 and that I last saw him alive on Aug. 16 1946

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey E. MacMillan M. D.
Address City Hosp. Date signed 8/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43032

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V121a

Registered No. G43032

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 Division St.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town New Bern
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barrett, Leander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52 ?			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] Aug. 20 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Lobeth Ave

18 (a) Funeral director Lobeth Funeral Home
(b) Address 1216 E. Caroline St.

AUG 20 1946 (b) Huntington Williams, Md.
(Registered by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 - 1946, at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1946 to 8-18 1946, and that I last saw him alive on 8-18 1946.

Immediate cause of death	Duration
Hypertensive Cardiovascular Renal disease	
Due to Arteriolar nephrosclerosis	
Due to	
Other Conditions Rt. sided Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 307 N Carolina Ave Date signed Aug 19 1946

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58 B

Registered No. G43033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM V CRUMLEY (WILLIAM VERNON CRUMLEY)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	212-12-2752	M	W	Married

6 (b) Name of husband or wife Evelyn Crumley
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) July 23, 1919

8. AGE: Years	Months	Days	If less than one day hr.	min.
27	0	23		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Sheet metal Worker
11. Industry or business

FATHER
12. Name William V. Crumley, Sr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ida Souders
15. Birthplace Harford County, Md.

16 (a) Informant Mrs. Evelyn Crumley
(b) Address 1800 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

AUG 20 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1946 at 4 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1946 to 8/18 1946.
and that I last saw h/M alive on 8/18 1946.

Immediate cause of death PULMONARY EDEMA — Duration 5 DAYS

Due to SUBACUTE BACTERIAL ENDOCARDITIS

Due to RHEUMATIC HEART DISEASE

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M.D.
Address MD. GEN. HOSP. Date signed 8/18/46

G43034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G43034 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Arguith Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosetta Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 9, 1912

8. AGE: Years: 34 | Months: - | Days: 7 | If less than one day: hr. min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual Occupation: Store keeper

11. Industry or business

FATHER — 12. Name: Joseph Johnson
13. Birthplace: Md.

MOTHER — 14. Maiden Name: Agnes ?
15. Birthplace: Md

16 (a) Informant: Rosetta Johnson
(b) Address: 500 N. Arguith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 20 1946 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial
Location

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 522 N. Schroeder St.

19 (a) AUG 20 1946 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1946, at 9:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15-46 at 5:05 P. M.
(b) Where did injury occur? 500 Arguith St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Blunt force

23. Signature: Howard J. Madden M.D. Medical Examiner
Date signed 8-16-46

G43035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43035 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virgie Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Charles Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1898

8. AGE: Years	Months	Days	If less than one day
48	7	11	hr. min

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name	William Pollard
13. Birthplace	Va.
MOTHER 14. Maiden Name	Virgie ?
15. Birthplace	Va.

16 (a) Informant Charles Robinson
(b) Address 813 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1946 (month, day, year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2229 N. Johnson St.

19 (a) AUG 20 1946 (Date received by registrar) Registrar for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1946, at 6:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary T.B.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gubrinski M.D.
Medical Examiner.
Date signed 8/17/46

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

C43036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. C43036

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Perkins Ave.
(c) Hospital or institution:

17 / 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Perkins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence R. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 6, 1885

8. AGE: Years	Months	Days	If less than one day
61	5	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edgar Scott
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary E. Campbell
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Catherine A. Duvall
(b) Address 606 Perkins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Millia Lamoreau
(b) Address 1003 W. Baltimore St.

AUG 20 1946 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946, at 2.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1946 to August 17 1946, and that I last saw h[illegible] alive on August 17 1946

Immediate cause of death Carcinoma breast

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis DeGaa MD M. D.

Address 876 Washington Blvd. Date signed

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please

File 643037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered 643037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner of Richmond & Green St.
(c) Hospital or institution:
University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Argyle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Frank

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Married

6 (b) Name of husband or wife Mable Frank
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-7-1908.

8. AGE: Years	Months	Days	If less than one day
37	9	10	hr. min.

9. Birthplace North - South Carolina (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name WILLIE FRANK.
13. Birthplace S.C.

MOTHER
14. Maiden Name CORINE WRIGHT.
15. Birthplace S.C.

16 (a) Informant MABEL FRANK.
(b) Address 933 ARGYLE-AVE.

17 (a) SHIPPED (Burial, cremation, or removal) (b) Date thereof 8-22-46 (month) (day) (year)
(c) Cemetery or crematory TRINITY CEM.
Location FLORENCE. STH. CAROLINA

18 (a) Funeral director Williams & Jackson
(b) Address 964 Pennsylvania ave

19 (a) AUG 20 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1946, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1946 to 8-19 1946, and that I last saw him alive on 8-19 1946.

Immediate cause of death Shock — Duration

Due to Ruptured Abdominal Aneurism

Due to

Other Conditions Carcinoma of the rectum (Include pregnancy within 3 months of death)

Date of operation 8-9-46

Major findings of operation: Ruptured Abdominal Aneurism

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Emergency Hospital Date signed 8-19-46 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G43038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G43038

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Warren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/11

8. AGE: Years 35 | Months | Days | If less than one day: hr. min

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Corp.

FATHER
12. Name Buck Warren
13. Birthplace N. C.

MOTHER
14. Maiden Name Sallie Anna Warren
15. Birthplace N. C.

16 (a) Informant Jay Williams
(b) Address 1817 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blanton

19 (a) (Date received by registrar) AUG 20 1946 Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946, at 5:46 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculous pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Moseley M.D.
Medical Examiner.
Date signed 8/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43039 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5th
(e) Length of stay in Baltimore (yrs., mos., or days) 5th

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Low Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY HANSON or (May J. Blake)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Joseph Moseley

13. Birthplace Md.

MOTHER 14. Maiden Name Caroline ?

15. Birthplace Md

16 (a) Informant Elizabeth Lane

(b) Address 1116 Low St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16/46 19 , at 1.00 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atherosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John T. Owens M.D.
Medical Examiner.

Date signed 8/16/46

X

HEALTH DEPARTMENT—CITY OF BALTIMORE

G43040 CERTIFICATE OF DEATH 124B G43040

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3211 Elliott St. 6-11 St. ..... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 60 yrs. 7 mos. ..... da. How long in U. S. If of foreign birth ..... yrs. ..... mos. ..... da. 76

2. FULL NAME AUGUST FREDERICK MOHRMAN

If U. S. Veteran specify WAR .....

(a) Residence: No. 3211 ELLIOTT ST. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Sept. 12, 1876

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	11	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME not known

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME not known

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs. Marie Coleman
(Address) 3418 Elliott St.

18. BURIAL, CREMATION, OR REMOVAL
Place Oak Lawn Date 8/21/46

19. UNDERTAKER Clarence F. Hoffmann
(Address) 1639 Broadway

20. FILED AUG 20 1946 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) AUG. 18, 1946

22. I HEREBY CERTIFY, That I attended deceased from JULY 10, 1946 to AUG. 18, 1946.

I last saw him alive on AUG. 1, 1946. Death is said to have occurred on the date stated above, at 3 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
ARTERIOSCLEROSIS	10-12 Yr.
CIRRHOSIS LIVER	10 Yrs.
PULMONARY EDEMA	Aug. 17 '46

Other contributory causes of importance:

Was an operation performed? NO Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? NONE Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify .....

(Signed) Benjamin Hilkevitch, M. D.

(Address) 124 S. HIGHLAND AVE.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G430-1 Auer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G430-1 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Edgeville Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Settan

3 (b) **If veteran, name war**

3 (c) **Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) **Name of husband or wife**

6 (c) **If alive, give age** years

7. **Birth date of deceased** (mo., day, yr.) 8/19/46

8. AGE: Years	Months	Days	If less than one day
0	0	0	20 hr. 1 min.

9. **Birthplace** Baltimore Md. (Town, county, and state)

10. **Usual Occupation** —

11. **Industry or business** —

FATHER
12. Name Charles J. Settan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Madeline Stout
15. Birthplace Baltimore, Md.

16 (a) **Informant**
(b) **Address**

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood. Location Taylor ave

18 (a) **Funeral director** Clarence P. Hoffman
(b) Address 1115 E. Broadway

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 8/20 1946, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1946 to 8/20 1946, and that I last saw her alive on 8/20 1946.

Immediate cause of death atelectasis of lung. — Duration

Due to Mucous plug.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** M. W. Gregg M.D.
Address Md. Gen. Hosp. Date signed 8/20/46 M. D.

VS 150

G43042
JL-1029 08

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 587

Registered No. G43042

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution BALTIMORE CITY HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N.Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Avone Watkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1936

8. AGE: Years	Months	Days	If less than one day
10	6	21 20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Eugene Watkins
13. Birthplace Md.

MOTHER
14. Maiden Name Katheryn Wright
15. Birthplace Baltimore, Md.

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore Md
18 (a) Funeral director Charles B. Cooper
(b) Address 612 N. Carrollton Ave.
19 (a) (Date received by Registrar) AUG 20 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1946, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946, to Aug. 16 1946, and that I last saw him alive on Aug. 16 1946.

Immediate cause of death	Duration
Cardiac insufficiency	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy Rheumatic pancarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilson C. Hughes. M. D.
Address B. C. H. Date signed 8-17-46

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RIGHTS RESERVED FOR BINDING

G43043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G43043 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL William DUGENT

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-14-7660

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mariella Allen Dugent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1882

8. AGE: Years	Months	Days	If less than one day
64	7	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Horn & Horn

FATHER
12. Name William Dugent
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lutz
15. Birthplace Balto., Md.

16 (a) Informant Mr. Charles A. Dugent
(b) Address 2734 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/46 19 , at 4.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1946 to 8/18 1946, and that I last saw HIM alive on 8/18 1946.

Immediate cause of death BRONCHO-PNEUMONIA, LEFT — Duration 3 MOS. 22 DAYS

Due to PYOTHORAX, RT

Due to

Other Conditions PULMONARY TUBERCULOSIS, LEFT
(Include pregnancy within 3 months of death)

Date of operation 5/20 1946

Major findings of operation: TUBERCULOSIS RT. LUNG, TERMINAL PNEUMONIA, LEFT

of autopsy: TB, LEFT, PYOTHORAX RT

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart Jr.

Address MD. GEN. HOSP. Date signed 8/19 1946

Aug 20 1946 [illegible] Williams, M.D.

G43044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G43044 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER RUSSO

3 (b) If veteran, name war	3 (c) Social Security Account No.		
Spanish American	212-18-0422		
4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.	
Male	White	Widower	

6 (b) Name of husband or wife Anna Catherine Russo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1881

8. AGE: Years	Months	Days	If less than one day
65	1	26	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Buyer
11. Industry or business Serio-Fruit Co.

FATHER
12. Name Charles Russo
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Dorothy Berends
(b) Address 918 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) AUG 20 1946 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1946, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22-44 to 8-17-46 and that I last saw him alive on 8-15 1946.

Immediate cause of death Tuberculosis — Duration 18 days?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S Berends M. D.
Address 2203 Edmondson Date signed 8-19-46

VS 150

G43045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G43045

Registered No.

49156.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 340 E. 23½ St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Blanks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-11

8. AGE: Years	Months	Days	If less than one day
34	8	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name James Blanks
13. Birthplace N.C.

MOTHER
14. Maiden Name Rev. Revy
15. Birthplace N.C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 22 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (b)

(Date received by registrar) AUG 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1946, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1946 to Aug. 19 1946 and that I last saw her alive on Aug. 19 1946

Immediate cause of death SUBARACHNOID HEMORRHAGE — Duration 2 DAYS

Due to

Due to

Other Conditions Hypertensive Cardio-Vascular Disease — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maxwell Williams M. D.
Address Johns Hopkins Hosp Date signed 9-46

8:30a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

G43046
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2038 Myra St.
(c) Hospital or institution:

8-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 Myra St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Meyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ Geo. W. Meyer | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19 1878

8. AGE: Years 67 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Geo. Kirby
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Foster
15. Birthplace Md.

16 (a) Informant Geo. W. Meyer
(b) Address 2038 Myra St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)

(c) Cemetery or crematory Balto.
Location Balto Md.

18 (a) Funeral director G. F. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (b)
(Date received by registrar) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945 to Aug 18 1946, and that I last saw h alive on Aug 1 1946.

Immediate cause of death — Duration

Valvular Heart disease — 1 yr

Due to

Due to

Other Conditions Arteriosclerosis
Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Fisher M. D.

Address 1823 N. Wash. St. Date signed 7/19/47

G430:7 G430:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3321 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3321 Falls Road (Or other description or location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Elmer Tracey

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7278

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Rosemary Tracey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13 - 1903

8. AGE: Years 42 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business American Cyanamid Co

FATHER 12. Name James F. Tracey
13. Birthplace Maryland

MOTHER 14. Maiden Name Grace V. Abernathy
15. Birthplace Maryland

16 (a) Informant Mrs Mary V. Tracey
(b) Address 3321 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21-1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

AUG 20 1946

VS 80

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 - 1946, at 9 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1941 to Aug 18 1946, and that I last saw h[illegible] alive on Aug 17 1946.

Immediate cause of death

Due to Uremia — Duration: 2 weeks
Due to Chronic Nephritis — 3 Months
Due to Chronic Myocarditis — 3 months.
Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert H. Mortimer Jr. M. D.
Address 2706 St Paul St Date signed 8/19/46

G43048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43048 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4316 Grandview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4316 Grandview Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Leonard Harner

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-6591

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ola May Harner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31-1888

8. AGE: Years 57 Months 9 Days 20 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Carroll Ind. Fruit Co

FATHER 12. Name Frank Harner

13. Birthplace Maryland

MOTHER 14. Maiden Name Emma Leonard

15. Birthplace Maryland

16 (a) Informant Mrs Ola May Harner

(b) Address 4316 Grandview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23-1946 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) AUG 21 1946 (b) [illegible] Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20. 1946 at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1946 to Aug 20 1946 and that I last saw him alive on Aug 19 1946.

Immediate cause of death Coronary Occlusion — Duration 7 hrs.

Due to Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)

(e) Means of injury

23. Signature [signature]

Address 846 W 36th St. Date signed Aug 20/46

VS 150

G43049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5937 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5937 Falls Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Guy A. Luttrell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Patience J. Luttrell
6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) July 23-1875

8. AGE: Years 70 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Jonesboro Tennessee (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER
12. Name Samuel Luttrell
13. Birthplace Tennessee

MOTHER
14. Maiden Name Margaret Harris
15. Birthplace Georgia

16 (a) Informant Mrs. Patience J. Luttrell
(b) Address 5937 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21-1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee, Shepard Howe
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1946 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1946 to Aug 19 1946, and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis

Duration 14 days

Due to Rupture of Coronary artery

Due to Generalized Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Herman R Wentz M. D.
Address 360 Manhattan Ave Date signed 8/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. G13050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 639 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine Johnson Henry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1934

8. AGE: Years	Months	Days	If less than one day
12	5	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Josiah Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Annie King
15. Birthplace Florida

16 (a) Informant Mary James
(b) Address Route #16 Box 349 - Hyde Post

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery Mollyneck
Location Mollyneck Anne Arundel

18 (a) Funeral director A. Gilstead
(b) Address 2145 Druid Hill Ave.

19 AUG 20 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1946 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Due to Chr. obliterating pericarditis
Due to Hypertrophy + dilatation of heart
Other Conditions Confestion of viscera - Anasarca - Abd. Kidney + Ascites

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 8/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43051 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Boston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Boston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella B. Zinkand

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem'l | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1881

8. AGE: Years	Months	Days	If less than one day
65	6	11	hr. min.

9. Birthplace Trenton N.J. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Fred Hitt
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Hines
15. Birthplace Germany

16 (a) Informant John Zinkand
(b) Address 3405 Boston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John E. McGrain
(b) Address 6000 Baltimore St

19 (a) AUG 20 1946 (b) Registrar Lexington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 18 1946 to Aug 19 1946, and that I last saw h[er] alive on Aug 19 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage & Pulmonary Oedema	Aug 18-1946
Due to Hypertension	1942
Due to Myocarditis	1942
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Kelleman M. D.
Address 346 Bush St Date signed Aug 19-46

VS 150

G43052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G43052 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Mc Elderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3114 Mc Elderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna May Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Howard A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24 1900

8. AGE: Years 46 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Frank Stuart
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Emma Rever
15. Birthplace Baltimore Md

16 (a) Informant Howard A. Jones
(b) Address 3114 Mc Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director John G Moran
(b) Address 3600 Baltimore St

19 (a) (Date rec'd by registrar) AUG 20 1946 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1946 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 18 1946 and that I last saw h[illegible] alive on Aug 18 1946.

Immediate cause of death: Cardio-renal vascular disease — Duration 5 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury SAWYER

23. Signature George Deringer M.D.
Address 4808 Harford Rd. Date signed 8/20/46

G43053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G43053 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 Homestead St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren Thomas Brown

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 214-01-5863

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rena Brown

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1887

8. AGE: Years: 59 Months: 2 Days: 17 If less than one day: hr. min.

9. Birthplace: Elkton Md
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Garden Hospital Supplies

FATHER 12. Name: Thomas Lord Brown

13. Birthplace: Cherry Hill Md

MOTHER 14. Maiden Name: Mary Smith

15. Birthplace: Md

16 (a) Informant: Rena Brown

(b) Address: 1403 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/21/46 (month) (day) (year)

(c) Cemetery or crematory: Parkton Md

Location: Parkville Md

18 (a) Funeral director: Fulton Cook Co

(b) Address: 1210 W Fayette St

19 (a) AUG 20 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19 1946, at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1946, to Aug. 19 1946, and that I last saw deceased alive on Aug. 19 1946.

Duration: June 1, 1946 to Aug. 19 1946

Due to Metastatic Carcinoma from Pancreas

Due to

Other Conditions Cirrhosis -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at (work)
(e) Means of injury

23. Signature: [illegible]

Address: Emergency Hosp. Date signed: Aug. 20 1946

VS 150

G43054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 181

G43054

Registered No. Orig

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Pylesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert (Earl) Walter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hazel S. Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-1908

8. AGE: Years	Months	Days	If less than one day
38 (37)	6	14	hr. min.

9. Birthplace Harford Co Md
(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name Robert S. Walter
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Margaret Thompson
15. Birthplace Harford Co. Md.

16 (a) Informant Hazel S. Walter
(b) Address Cardiff, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/46 (month) (day) (year)

(c) Cemetery or crematory Slate Ridge
Location York Co. Penna.

18 (a) Funeral director Herbert P. Hardman
(b) Address Delta, Pa.

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1946, at 9:14 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Deep incised burns on anterior surface 80 to 90% of the body

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-17-46 at 9:30 P. M.
(b) Where did injury occur? Enroute to Lancaster, Pa.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury gasoline poured & clothes caught fire while lighting cigarette

23. Signature Armand J. Waddell M.D.
Medical Examiner

Date signed 8-20-46

X

G43055 filed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G43055 157 M

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns Sts.
(c) Hospital or institution:
Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs 58 min
(e) Length of stay in Baltimore (yrs., mos., or days) New Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 - 4th Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Moulton (MARY JEAN MOULTON)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: single

6 (b) Name of husband or wife: New born

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1946

8. AGE: Years | Months | Days | If less than one day: 4 hr. 58 min.

9. Birthplace BALTIMORE City, MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name HENRY HAMMOND MOULTON, JR.

13. Birthplace BALTIMORE, Md

MOTHER 14. Maiden Name Leah Louise Jordan

15. Birthplace BALTIMORE, Md

16 (a) Informant HENRY HAMMOND MOULTON

(b) Address BALTIMORE, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

AUG 20 1946 (Date rec'd by registrar) (b)

Kensington Willis Register M.D.

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1:32 P.M. 8/19/1946, to 6:30 P.M. 8/19/1946, and that I last saw h.e.l. alive on August 19 1946

Immediate cause of death: Respiratory Failure. — Duration

Due to Multiply congenital abnormalities

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address Women's Hospital Date signed 8/19/46

G43056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43056

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address North Broadway.

(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Essex (If outside city or town limits, write RURAL and give town)

(d) Street No. 612 Franklin Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William Schlutes

3 (b) If veteran, name war	3 (c) Social Security Account No.
None.	None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie Schlutes

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day hr.	min.
80.	?	?		

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Upholsterman.

11. Industry or business Factory

FATHER 12. Name Wm Schlutes.

FATHER 13. Birthplace Germany.

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Germany.

16 (a) Informant Wife of Peter

(b) Address 600 Franklin Ave. Essex

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)

(c) Cemetery or crematory

Location Norfolk Virginia

18 (a) Funeral director John P. Connelly.

(b) Address 418 Eastern Ave. Balto 21.

19 (a) 1946 (Date rec'd by registrar) Sturgeon Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19, 1946 at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1946 to Aug 19 1946 and that I last saw h[illegible] alive on Aug 19, 1946.

Immediate cause of death	Duration
Bronchial pneumonia	3 days
Due to	
Due to	
Other Conditions Arteriosclerotic heart disease	20 yrs.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Bachanel.

Address Church Home Hosp Date signed 8/21/46

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G43057 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 S. Grundy St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County B
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 S. Grundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Joseph Rowland.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of ~~husband~~ or wife Brigit Conway. 6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Aug 17 1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	-	1		

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business –

FATHER
12. Name Thomas Rowland
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigit Finley
15. Birthplace Ireland

16 (a) Informant Mrs. Brigit Rowland.
(b) Address 614 S. Grundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart.
Location Dorman Hill Rd.

18 (a) Funeral director John S Connelly
Address 418 Eastern Ave. Essex 21, Md.

19 (a) AUG 20 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18-46 19 . at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1-46 19 . to 5-5 19 .
and that I last saw h alive on 5-7 19 .

Immediate cause of death Arteriosclerotic Cardiovascular disease — **Duration**
Due to Generalized Arteriosclerosis
Due to
Other Conditions Cerebral Thrombosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John Constantine M.D.
Address 234 N. Conkling Date signed 8-18-46

BC# B18063 AB-103822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43058 / G43058 Registered No. / 12B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 4days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County AnneRandell
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
Route 2- Box 409 -A- Annapolis
(d) ~~Street No.~~ (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerry Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colo	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2-1945

8. AGE: Years	Months	Days	If less than one day
1	6	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Brewer
13. Birthplace Conn.

MOTHER
14. Maiden Name Loretta Anderson
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) AUG 21 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20- 1946, at 4.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1946, to 8-20 1946, and that I last saw her alive on 8-20- 1946.

Immediate cause of death	Duration
Tuberculous Meningetis	1 wk
Due to	
Due to	
Other Conditions Miliary Tuberculosis	4mos?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Miliary Tbc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Duffin, M. D.
Address Balt City Hosp Date signed Aug 20 1946

VS 150

G43059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1214

G43059 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Ballow Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mell Joe Ciambatti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~ or ~~divorced~~.
Male	White	married

6 (b) Name of ~~husband~~ or wife Helen D. Memmo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 4, 1919

8. AGE: Years	Months	Days	If less than one day
27	6	16	hr. min.

9. Birthplace Juniata, Pa
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Vincenzo Ciambatti
13. Birthplace Italy

MOTHER
14. Maiden Name Luitgetta Miscianne
15. Birthplace Italy

16 (a) Informant Ruby Jo Ciambatti
(b) Address 1115 St Joseph, Alexandria Va.

17 (a) Burial (b) Date thereof Aug 20/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Tyrone, Pa

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Date received by registrar Aug 21 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1946, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1946, to 8-20 1946, and that I last saw him alive on 8-20 1946.

Immediate cause of death Uremia — Duration

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 6-7-46
Major findings of operation: Small, contracted kidneys
of autopsy: Chronic Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Swan Hosp Date signed 8-20-46

VS 150

G43060 BC# AB- 103635 G 53952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G43060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Green - Baby Girl- Twin B-

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10-1946

8. AGE: Years	Months	Days	If less than one day
			10 hr. 8 min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Willie Green
13. Birthplace N.C.

MOTHER
14. Maiden Name Inez Rose
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug 15. 1946 (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 AUG 21 1946 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10- 1946 at 8.16 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10- 1946 to 8-10- 1946 and that I last saw h 9F alive on 8-10- 1946.

Immediate cause of death	Duration
Respiratory distress	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wilson E. Hughes M. D.
Address Balto. City Hosp. Date signed Aug 19 46

VS 150

G43061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1321a

G43061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 E 31st St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 E 31st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Carroll Freeland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	W.

6 (b) Name of husband or wife Clara Freeland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 27-1874

8. AGE: Years	Months	Days	If less than one day
72	3	22	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Carpenter - Bldr

11. Industry or business

FATHER 12. Name Edward C Freeland
13. Birthplace Balto Md

MOTHER 14. Maiden Name Gribbon
15. Birthplace Baltimore

16 (a) Informant Dorothy Jenkins
(b) Address 3150 Lyndale Ave

17 (a) Burial (b) Date thereof Aug 21-1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Wm Cook Son
(b) Address 1417 St Paul St

19 AUG 21 1946 (a) Huntington Ave Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946, at 1:10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946 to Aug 19 1946, and that I last saw h alive on Aug 19 1946.

Immediate cause of death Coronary thrombosis

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1331 S Monroe St Date signed 8-19-46

G43062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1716

Registered No. G43062

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 - Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Smith

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 29 1930

8. AGE: Years: 15 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Student

11. Industry or business

FATHER
12. Name: George Russell Smith
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Genevieve M Bennett
15. Birthplace: Baltimore Md.

16 (a) Informant: George R. Smith
(b) Address: 1216 Linden Ave

17. Burial (Burial, cremation or removal) (b) Date thereof (month) (day) (year) 8/22/46
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md.

18 (a) Funeral director: Wallace & Foy
(b) Address: 1717 E. Fayette St.

19 (a) AUG 21 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1946 at 6:52 P.M.

21. I certify that I took charge of the remains described above, held an inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/19/46 at 6:40 P.M.
(b) Where did injury occur? Brevard & Howard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Run over by - Struck by trolley

23. Signature Howard F. Madden M.D. Medical Examiner.
Date signed 8/20/46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-103608 G43063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 107

Registered No. G43063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Compass Road-zone 20
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME William Slaughter

3 (b) If veteran, name war WWI

3 (c) Social Security Account No. 220-22-6835

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24- 1918

8. AGE: Years 27 Months ? Days 25 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Navy Dept New Repr Depot

FATHER
12. Name Percy Slaughter
13. Birthplace Va.

MOTHER
14. Maiden Name Grace Jory
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto

18 (a) Funeral director C. Howard Evans
(b) Address 1400 S. Charles St

19 (a) (Date received by registrar) (b)

AUG 21 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1946 at 11.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1946 to 8-19 1946 and that I last saw h im alive on 8-19 1946.

Immediate cause of death Respiratory Failure
Due to Tuberculosis & Bronchopneumonia
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. L. Scarborough, M.D.
Address Balto. City Hosp. Date signed 8-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1233a

Registered No. G43064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secour Hospital
(c) Hospital or institution: Payson & Fayette Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Belmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES JOHN DEMUTH

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 5/22/1927
8. AGE: Years 19 | Months 2 | Days 29 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Peter St. Muth
13. Birthplace Hungary

MOTHER
14. Maiden Name Pauline Muth
15. Birthplace Hungary

16 (a) Informant Mrs. Peter St. Muth
(b) Address 3604 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location 4430 Belair Road

18 (a) Funeral director Edward Conant Sons
(b) Address 941-43 E. Fallsway

19 (a) — (b) —

AUG 21 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 19 46, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1946, to Aug 20 1946, and that I last saw him alive on Aug 20 1946.

Immediate cause of death Acute pulmonary edema — Duration —
Due to Leukemia — —
Due to — —
Other Conditions Hypertension, pyelonephritis — —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature William F. Barr M. D.
Address Bon Secour Hosp. Date signed 8/21/46

G43065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43065 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2884 Kentucky Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Leroy Downs

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Josephine B. Downs
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Maintenance Man.
11. Industry or business

FATHER
12. Name William L. Downs
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lillian M. Welfel
15. Birthplace Baltimore, Maryland

16 (a) Informant Josephine B. Downs
(b) Address 2884 S. Kentucky Avenue

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-22-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Road

18 (a) Funeral director Frederick D. Miller
(b) Address 3019 E. Monument St

19 (a) Date received by Registrar AUG 23 1946 (b) Registrar Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1946 at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereof and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira, Medical Examiner, M.D.
Date signed 8-19-46

G43056 ✓ G43056

BALTIMORE CITY HEALTH DEPARTMENT

CM. 98960 **CERTIFICATE OF DEATH** 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-& 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Green St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Hale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Katie (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4th 1890

8. AGE: Years	Months	Days	If less than one day
56	5	13	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anderson Hale
13. Birthplace Va.

MOTHER
14. Maiden Name Ella (?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Monument St

19 (a) AUG 21 1946 (Date received by registrar) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17th 1946 at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 19 46 to Aug. 17 19 46 and that I last saw him alive on Aug. 17 19 46.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 day

Due to Hypertension arterio sclerosis disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Rowell Hoffmeister

Address Baltimore City Hosp Date signed 8-19-46

VS 150

X

G43057 — BALTIMORE CITY HEALTH DEPARTMENT — G43057 Registered No.

CERTIFICATE OF DEATH 12a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 272 Church hill
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 E. Churchill (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred Clock

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Col	Married

6 (b) Name of husband or wife Lucy Clock
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) —— 1885

8. AGE: Years	Months	Days	If less than one day
57	—	—	hr. min.

9. Birthplace Clarksville Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Fertilizer Works

FATHER
12. Name Albert Wisd
13. Birthplace Clarksville Va

MOTHER
14. Maiden Name Mary
15. Birthplace Clarksville Va

16 (a) Informant Lucy Clock
(b) Address 27 E Churchill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-46 (month) (day) (year)
(c) Cemetery or crematory Mt Lincoln
Location Balto City

18 (a) Funeral director Isaac L Bromwell
(b) Address 108 W Montgomery St

19 (a) AUG 21 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1946, at 7 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1946, to 8/19 1946 and that I last saw him alive on 8/18 1946.

Immediate cause of death	Duration
Myocarditis	
Due to Hypertension	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D and B Saunders M. D.
Address 1111 Eutaw Pl Date signed 8/20/46

VS 150 — Huntington Williams, M.D. — X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43068 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 Sharp Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA CARPENTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Robert Ford
13. Birthplace Va

MOTHER 14. Maiden Name Martha Healy
15. Birthplace Va

16 (a) Informant William Ford
(b) Address 935 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md

18 (a) Funeral director Isaac T Brown's Son
(b) Address 1098 W Montgomery St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16/46 19 at 6:30 A M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Huntington Williams M.D.
Medical Examiner.
Date signed

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43069 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis C. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War Two	217-07-2714

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frieda L. Smith
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) July 2, 1906

8. AGE: Years	Months	Days	If less than one day
40	1	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Charles T. Brandt Co.

FATHER
12. Name Conrad Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sophia Henkel
15. Birthplace Baltimore

16 (a) Informant Mrs Frieda L. Smith
(b) Address 114 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-46 (month) (day) (year)
(c) Cemetery or crematory Meadow Mingo
Location Wash. Blvd. Elkridge.

18 (a) Funeral director Frederick R. Wolf
(b) Address 1200 W. Lombard St.

19 (a) (b) Registrar Huntington Williams Mgr.

AUG 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1946 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 1946 to 8/19 1946, and that I last saw h alive on 8/18 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to: Angina Pectoris — 2 mo
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Kaczmarek
Address 1847 W. North Ave Date signed 8/21/46

X

G430.70

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

G430.70

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 ETTING Street
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 234D

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 ETTING Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	Colored	Widow

6 (b) Name of husband or wife DEAD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1875

8. AGE: Years	Months	Days	If less than one day
71	2 3	8	hr. min.

9. Birthplace Bucksport, S. Carolina (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER:
12. Name SAMUEL J. McFALL
13. Birthplace Bucksport, S. CAROLINA

MOTHER:
14. Maiden Name Betsy ?
15. Birthplace Bucksport, S. CAROLINA

16 (a) Informant ZELENA HARLEY
(b) Address 2005 N. ETTING Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory ARBUTUS MEM. PK.
Location BALTIMORE CO. MD.

18 (a) Funeral director MRS. GEO. H. HOLLAND
(b) Address 1631 DRUID HILL AVE.

19 (a) AUG 21 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1946, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 16, 1946, to August 18, 1946, and that I last saw her alive on August 18 1946.

Immediate cause of death CARDIAC Failure — Duration Several hrs.

Due to CARDIO-RENAL Disease — Several MONTHS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M.D.
Address 1607 W. Mulberry St. Date signed 8/18/46

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G43071 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 E. Camber St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Small, James

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	198-01-0285

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1886

8. AGE: Years	Months	Days	If less than one day: hr	min
60	-	19		

9. Birthplace Phila, Pa. (Town, county, and state)
10. Usual Occupation Quartermaster
11. Industry or business Seafarer

FATHER
12. Name Wm. Small
13. Birthplace Phila, Pa.

MOTHER
14. Maiden Name Catherine Miller
15. Birthplace Phila, Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-46 (month) (day) (year)
(c) Cemetery or crematory Govans
Location Belleora Ave
18 (a) Funeral director Odenheimer Funeral Home Inc.
(b) Address 4644 York Road
19 (a) (b)

AUG 21 1946

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1946 at 9:26A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1946 to Aug. 19 1946, and that I last saw him alive on Aug. 19 1946.

Immediate cause of death Aortitis, calcific, severe — Duration UNKNOWN

Other condition: Cirrhosis of liver — UNKNOWN

Other conditions: Hydronephrosis & pyelonephritis severe due to urethral stricture — UNKNOWN

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 8/20/46 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

G43072

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43072 Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 S. Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Chester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lewandowski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 1859

8. AGE: Years	Months	Days	If less than one day
87	5	-	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B. O. R.R. Co.

FATHER
12. Name ? Lewandowski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Elizabeth Glass
(b) Address 8 S. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Balto. City

18 (a) Funeral director John J. Weber
(b) Address 401 S. Chester Street

AUG 21 1946
(a) Registrar (b) Registered Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION 845

20. DATE OF DEATH Aug 19 1946 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1946 to Aug. 19 1946 and that I last saw him alive on Aug. 19 1946

Immediate cause of death
CORONARY SCLEROSIS — Duration 7/27/46
Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DIS. — ???
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Krenzer, M.D.
Address 209 N. Chester St Date signed 8/20/46

×

BC# D39243 G43073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G43073 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Caton Ave
(c) Hospital or institution: St Agnes Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S Augusta Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Beth Martina Gratz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/5/46

8. AGE: Years	Months	Days	If less than one day
	7	16	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER 12. Name Morton Gratz
13. Birthplace Pa

MOTHER 14. Maiden Name Mary Elizabeth James
15. Birthplace Pa

16 (a) Informant Dr. Morton Gratz
(b) Address 318 S. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory
Location Milton Pa.

18 (a) Funeral director Martin Tabor Jones
(b) Address 1827 N. North Ave.

19 (a) (Date rec'd by reg.) (b) Washington Williams, Registrar

22 1946

VS 18a

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 August 1946, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Aug 1946 to 21 Aug 1946 and that I last saw her alive on 21 Aug 1946. Immediate cause of death: Cardiac failure

Due to Wilms Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 20 Aug 46

Major findings of operation: Wilms Tumor

of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald W Menzer
Address St Agnes Hosp Date signed 27 Aug 46

G43074 BALTIMORE CITY HEALTH DEPARTMENT G43074

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 371 N. Carey
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Hp

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 371 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vesty Hawthorne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or divorced
Male	col	Married

6 (b) Name of ~~husband~~ or wife Susie Hawthorne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29- 1906

8. AGE: Years	Months	Days	If less than one day
40	4	22	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Hawthorne
13. Birthplace S.C.

MOTHER
14. Maiden Name Hattie Agnew
15. Birthplace S.C.

16 (a) Informant Susie Hawthorne
(b) Address 1128 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George Gilchrist
(b) Address 1303 Presstman St

19 (a) 1946 (b) (Filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20- 1946 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20 1946 to 8-20-1946 and that I last saw him alive on 8-20 1946.

Immediate cause of death Hypostatic Cardio-Renal Disease.
Due to acute cardiac dilatation
Due to
Other Conditions

Duration
2 Mos,
1 day.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature R. L. Jackson
Address Coon & Slaughter Funeral Home Date signed 8-24-46
R. L. Jackson

G43075 Roseborough G43075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1242

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 678 Bradley Street
(c) Hospital or institution: Drew & Lombard

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 678 Bradley Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George Roseborough ROSEBOROUGH

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Elizabeth Roseborough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 Months Days If less than one day hr. min.

9. Birthplace Blackstock S. C. (Town, county, and state)

10. Usual Occupation Janitor,

11. Industry or business Hauling

FATHER 12. Name Allen Roseborough

13. Birthplace Blackstock S. C.

MOTHER 14. Maiden Name Caroline Roseborough

15. Birthplace Blackstock S. C.

16 (a) Informant Ruth Washington

(b) Address 1647 E Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)

(c) Cemetery or crematory

Location Blackstock S. C.

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Bryant St and Huntington Ave

19 AUG 21 1946 (b) Registrar

(Date filed by Registrar)

Refuses on insurance Policy.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19th 1946, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20, 1946, to Aug 19, 1946, and that I last saw him alive on Aug 16 1946.

Immediate cause of death Cirrhosis of the Liver — Duration a year

Due to malnutrition for two wks

Due to inability to swallow water vomiting nothing would stay on his stomach

Other Conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. B. Tokarsa M. D.

Address 926 N. Arlington Ave Date signed

G43076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G43076 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 E Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Hudson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Robert Hudson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Robert Hudson
(b) Address 305 N. Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave
(c) AUG 21 1946 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1946 at 8 25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Hoffman M.D. Medical Examiner
Date signed 16 Aug 46

VS 191

Age is especially important. Physicians: please write the causes of death clearly and legibly. ... information should be carefully supplied. The

JL - 103864 G43077 BALTIMORE CITY HEALTH DEPARTMENT G43077
CERTIFICATE OF DEATH 83B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Bonte Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
80 ?	?	?	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Wally
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brightly Ave
Date received 8-21-1946 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1946, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1946 to Aug. 17 1946, and that I last saw h ER alive on Aug. 17 1946.

Immediate cause of death	Duration
Circulatory Failure	
Due to Cerebral Hemorrhage ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. R. Hartzog M. D.
Address Balto. City Hosp. Date signed 8-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FG43078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. GA3078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Bonaparte Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OLA OLSEN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	717-07-6247	Male	White	Married

6 (b) Name of husband or wife Nora Olsen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1867

8. AGE: Years	Months	Days	If less than one day
79	5 3	4	hr. min.

9. Birthplace Sweden
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Pa. R. R.

FATHER
12. Name Unknown Olsen
13. Birthplace Sweden

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Nora Olsen
(b) Address 1010 Bonaparte Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Renova, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 21 1946 (Date received by Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1946, at 1.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1946, to 8/20 1946, and that I last saw h/M alive on 8/19 1946.

Immediate cause of death BRONCHOPNEUMONIA — Duration 5 DAYS

Due to CEREBRAL THROMBOSIS

Due to CEREBRAL ARTERIOSCLEROSIS

Other Conditions DIABETES MELLITUS
URINARY RETENTION
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD. GEN. HOSP. Date signed 8/20/46

824

G43079 DC# 40708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157a

Registered No. G43079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospl
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Patrick Henry Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Ann Donihoo

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29-46

8. AGE: Years	Months	Days	If less than one day
	7	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation baby
11. Industry or business

FATHER
12. Name Geo. S. Donihoo
13. Birthplace Pa

MOTHER
14. Maiden Name Frances Floto
15. Birthplace Connellsville Pa

16 (a) Informant Mr Donihoo
(b) Address 5301 Patrick Henry Drive

17 (a) Cremation (b) Date thereof Aug 21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hill Grove Cem
Location Connellsville Pa

18 (a) Funeral director Milton Schulting
(b) Address 3914 S Hanover St

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)
AUG 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1946, at 4:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hydrocephalus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Spilsbury M.D.
Medical Examiner.
Date signed 8/21/46

Please write the causes of death clearly and legibly. Physicians: please write as especially important. Information should be carefully supplied. The

G43030
498264.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G43030
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Vt
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Armistead Way (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 8-30-96

8. AGE: Years 55. Months 11 Days 22 If less than one day hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name David Winder
13. Birthplace Va

MOTHER
14. Maiden Name Rachel Widener
15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug 21-46 (month) (day) (year)
(c) Cemetery or crematory PLEASANT VIEW
Location KIDNERS FALLS, VA

18 (a) Funeral director John O Mitchell
(b) Address 1500 Eutaw Place

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 15 AUG 21 1946

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Aug. 21 1946 at 1.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1946 to Aug. 21 1946 and that I last saw him alive on Aug. 21 1946.

Immediate cause of death: Subarachnoid Hem. Thrombosis Long. Sinus

Due to: Cause as yet undetermined

Due to:

Other Conditions: Cervical Polyp Pyometra, Dental Caries

(Include pregnancy within 3 months of death)

Date of operation: 0

Major findings of operation: 0

of autopsy: 8/21/46

Duration: 3 hrs. 45 min. 3 hrs. 45 min.

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 21 Aug 46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43081
AB-102698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132a

G43081
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 S. Curley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Schader

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28- 1881

8. AGE: Years	Months	Days	If less than one day
64	11	22 2/3	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell Street.

18 (a) Funeral director John J. Duda.
(b) Address 2829 Hudson Street.

19 (a) AUG 21 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20- 1946, at 2.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1946 to 8-20- 1946, and that I last saw him alive on 8-20-46 1946.

Immediate cause of death: Respiratory Failure — Duration

Due to Uremia

Due to Chronic Pyelonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. C. Yearbrough, M.D.
M. D.
Address Balto City Hosp Date signed 8-20-46

G43032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G43032 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 Fait Avenue.
(c) Hospital or institution:
Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Fait Avenue.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A. Magersupp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9, 1889.

8. AGE: Years	Months	Days	If less than one day
56	8	11	hr. min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)
10. Usual Occupation Lt., Detective Hqs.
11. Industry or business

FATHER
12. Name Charles Magersupp
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Margaret Horn
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mary Magersupp (Wife)
(b) Address 2712 Fait Avenue.

17 (a) Burial (b) Date thereof 8/24/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Road.

18 (a) Funeral director John J. Duda.
(b) Address 2829 Hudson Street.

19 (a) AUG 21 1946 Huntington Williams Registrar
(Date received by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1946, at 6.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Aug. 20 1946 and that I last saw h— alive on Aug. 20 1946.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2329 Eastern Date signed 8/24/46

G43083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G43083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S. Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S. Patterson Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TEKLA JASKULSKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Vincent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/21/1866

8. AGE: Years	Months	Days	If less than one day
79	8	29	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michael Lewandowski
13. Birthplace Poland

MOTHER
14. Maiden Name Jozefa Limaneka
15. Birthplace Poland

16 (a) Informant Charles D. Sadowski
(b) Address 1808 Eastern Avenue

17 (a) Burial (b) Date thereof August 23.1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

AUG 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 20 1946 at 1115 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from MAR. 11 1944 to AUG. 20 1946 and that I last saw h er alive on AUG. 20 1946.

Immediate cause of death	Duration
BRONCHIAL PNEUMONIA	2 DAYS
Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DIS.	3 YEARS
Due to	
Other Conditions GLAUCOMA	??

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Duenga M. D.
Address 209 S. Chester St. Date signed 8/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G43084 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 Rexmere Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAROLINE MARGARET BRANZELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George L. Branzell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1895

8. AGE: Years	Months	Days	If less than one day
51	7	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Conrad Hoffman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Jerscheid
15. Birthplace Balto., Md.

16 (a) Informant Mr. George L. Branzell
(b) Address 3717 Rexmere Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 21 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1946 to Aug 19 1946 and that I last saw h. alive on Aug 19 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day
Due to: Malignant Hypertension — 8 mos.
Due to:
Other Conditions: none

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James G. Howell M. D.
Address 765 Frederick Rd. Date signed 8-21

X

G43085 BALTIMORE CITY HEALTH DEPARTMENT G43085
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania County
(c) City or town Woodbine (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted] Miller (Mary)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Elmer Richard Miller
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) August 19, 1924

8. AGE: Years	Months	Days	If less than one day
22	0	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Mr. Archie Little
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Neeper
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 8-24-46
(c) Cemetery or crematory Tabernacle Cemetery
Location Pennsylvania

18 (a) Funeral director H. P. Hankins
(b) Address Delta Pa.

19 (a) Received this certificate AUG 21 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1946 at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1946 to Aug. 21 1946 and that I last saw her alive on Aug 21 1946.

Immediate cause of death: Respiratory failure — Duration: 3 hrs.
Due to: Meningitis — 38 days
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia, acute, left lower lobe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul B. Tome, M.D.
Address Union Memorial Hosp. Date signed 8/21/46

G43086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G43086 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2726 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Jane Burke

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Andrew Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1859

8. AGE: Years 87 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward M Tracey
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Mary E Eccleston
15. Birthplace Md

16 (a) Informant Mary D Bradford
(b) Address 3743 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 22 46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Lombard

19 (a) AUG 22 1946 (b) Huntington Williams, M.D. Registrar
Filed by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946, at 9 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1946 to 8/19 1946, and that I last saw h[illegible] alive on 1/12 1946.

Immediate cause of death: Coronary occlusion — Duration 1/2 hr.
Due to Hypertension — ?
Due to Arteriosclerotic heart disease — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reitz, M.D.
Address 340 W Windsor Ave Date signed 8/21/46

G43087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G43087

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible] Memorial Hospital 9 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town [illegible] (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Montpelier (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Pfeiffer

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex f | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Richmond H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1906

8. AGE: Years 39 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name John Schramek
13. Birthplace Czechoslovakia

MOTHER 14. Maiden Name Mary (Unknown)
15. Birthplace Czechoslovakia

16 (a) Informant Richmond H Pfeiffer
(b) Address 1100 Montpelier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/46 (month) (day) (year)
(c) Cemetery or crematory Lindelwood
Location Baltimore Md

18 (a) Funeral director William Lehne
(b) Address 229 E Fort Avenue, Baltimore, Md

19 (a) AUG 2 1946 (Date accepted by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22/46 19 . at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
a. Hanging
b.
c.
Due to [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/22/46 at [illegible] M.
(b) Where did injury occur? Home
(c) Did injury occur (at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging

23. Signature [illegible] M.D. Medical Examiner.
Date signed 8/21/46

Please write the causes of death clearly and legibly. Physicians: please [illegible] supplied. The

G43033

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a ✓ G43033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 S. Woodyear St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19-3
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 S. Woodyear St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Norine Carlton McAllister

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robert Raymond McAllister
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) July 5, 1909

8. AGE: Years 37 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Front Royal, Va.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George Spicer
13. Birthplace Va

MOTHER
14. Maiden Name Annie Atkinson
15. Birthplace Virginia

16 (a) Informant Robert McAllister
(b) Address 3085 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Cook Inc
(b) Address 1217 Eutaw Pl Baltimore Md

19 (a) AUG 22 1946 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21, 1946 at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1946 to Aug 21 1946. that I last saw her alive on Aug 21 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 30 Minutes

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Alfred Cole M. D.
Address 1934 Wilkens Ave Date signed Aug 21 '46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The name, WITH UNFADING INK.

G43089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124 B

Registered No. G43089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Callendar St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Henthorn

3 (b) If veteran, name war: World War I.

3 (c) Social Security Account No. 218-14-8788

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Irene E. Henthorn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19. 1893

8. AGE: Years 52 | Months 10 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business Produce

FATHER
12. Name William J. Henthorn
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie Hartlove
15. Birthplace Baltimore Md

16 (a) Informant William J. Henthorn
(b) Address Riviera Beach. A.A. Co. Md

17 (a) Burial (b) Date thereof Aug 23. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road

18 (a) Funeral director Mr. & Mrs. John H. Tenfel & Son
(b) Address 801 W. Fayette St

19 AUG 22 1946 Huntington Williams M.D.
(Date received by local registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1946, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cirrhosis of the liver

Due to Esophageal varices
Ascites hydrothorax

Other Conditions General anasarca

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison, M.D.
Medical Examiner.
Date signed 8-20-46

G43090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G43090 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Carey - 3rd. Fl. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susanna Mc Coy.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widower

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
88			hr. min.

9. Birthplace Orland South Carolina (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Owens
13. Birthplace South Carolina

MOTHER 14. Maiden Name Mary ?
15. Birthplace South Carolina

16 (a) Informant James Spruce
(b) Address 208 N. Carey St.

17 (a) Burial (b) Date thereof Aug 19 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery [redacted] Mt. Calvary
Location Cedar Hill Md

18 (a) Funeral director A. Babchak
(b) Address 918 Druid Hill Ave.

AUG 22 1946 (Date filed) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946 to Aug. 17 1946 and that I last saw [redacted] alive on July 10 1946.

Immediate cause of death Hypertensive cardio-vascular disease

Duration 9

Due to (Hypertension Arteriosclerosis

Due to Senility

Other Conditions Cataracts of both eyes.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Walter Shennington M. D.
Address 201 N Carey St Date signed 8/21/46

VS 150

G43091 — BALTIMORE CITY HEALTH DEPARTMENT — G43091

AB-100359

CERTIFICATE OF DEATH 1362

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos. 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 748 Bradley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1872

8. AGE: Years	Months	Days	If less than one day
74	4	4	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Bradley
13. Birthplace Va.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery [redacted] Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

AUG 22 1946 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1946 at 9.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4- 1946 to 8-19 1946 and that I last saw him alive on 8-19 1946.

Immediate cause of death: Cerebral vascular hemorrhage — Duration 48 hrs

Due to: cause undetermined

Due to: Other Conditions: Gastric & rectal hemorrhage — Duration 48 hrs

(Include pregnancy within 3 months of death)

Date of operation 7-21-46 & 8-6-46

Major findings of operation: multiple urethral fistulae

Date of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas O'Donnell

Address Balto City Hosp Date signed 8-21-46

VS 150

G43092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

110 B

Registered No. G43092

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 S. Brunswick St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Lee L. Windhaus

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 18, 1915

8. AGE: Years: 31 | Months: 2 | Days: 2 | If less than one day: hr. ____ min. ____

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: Invalid

FATHER
12. Name: Frederick David Windhaus
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Elizabeth Streick
15. Birthplace: Germany

16 (a) Informant: Frederick W. Ritteyr
(b) Address: 538 S. Brunswick St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore, Maryland

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) ____ (b) Huntington Williams, M.D. (Signature of registrar)

AUG 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1946, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 1946 to Aug. 20 1946 and that I last saw him alive on Aug. 20 1946

Immediate cause of death: Lung abscess, Regurgitation, failure — Duration

Due to: Bronchus - pleural fistula, Primary Adenocarcinoma

Due to: Terminal aspiration

Other Conditions: Mental depression

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lung abscess (left)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: R. E. McCord M. D.
Address: University Hosp. Date signed 8-20-46

X

G43093 | BALTIMORE CITY HEALTH DEPARTMENT | G43093

CERTIFICATE OF DEATH 46B

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Edmonson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Lammon

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Penn Railroad

FATHER 12. Name Robert -

13. Birthplace

MOTHER 14. Maiden Name Muriah -?-

15. Birthplace

16 (a) Informant Horace Hall (friend)
(b) Address 1025 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1946, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1946 to 8/18 1946, and that I last saw h[illegible] alive on 8/18/ 1946.

Immediate cause of death: Respiratory failure — Duration

Due to Ca of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy 8/20/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G H Hassenbusch M.D.

Address [illegible] Mayo Date signed 8/20/46

VS 150

G43094 BCH D53518 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43094
Registered No.

CERTIFICATE OF DEATH 160a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Stanwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy goldstein
3 (b) If veteran, name war ✓
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel goldstein
13. Birthplace ?

MOTHER
14. Maiden Name Rose Go ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 20 1946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 22 1946 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1946, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1946, to 8/15 1946, and that I last saw he alive on 8/15 1946.

Immediate cause of death Respiratory Failure — Duration
Due to Cerebral Hemorrhage
Due to Birth Trauma
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work) (Specify type of place)
(e) Means of injury

23. Signature Eugene Goodelman M.D.
Address Sinai Hospital Date signed 8/19/46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-96405 G43095 BALTIMORE CITY HEALTH DEPARTMENT G43095

CERTIFICATE OF DEATH 479

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Lee St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Cheatham

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Essie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 50?

8. AGE: Years	Months	Days	If less than one day
50?	?	?	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Silas Cheatham
13. Birthplace ?

MOTHER
14. Maiden Name Etta Taylor
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 23 46 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Richmond Va

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison ave

19 AUG 22 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1945 to 8-21- 1946, and that I last saw him alive on 8-21- 1946.

Immediate cause of death	Duration
Cachexia	6 mos
Due to Carcinoma of lung & metastasis	12 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operations 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Worrell M. D.
Address Balto City Hosp. Date signed 8-22-46

Huntington Williams, MD

VS 150

G43096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

G43096 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Wks
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 N. Hilton St. (#16)
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Simon P. Dalton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife: Mary Dolan
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Mar. 21, 1858

8. AGE: Years	Months	Days	If less than one day
88	3 5	0	-- hr. -- min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: -------

FATHER
12. Name: John Dalton
13. Birthplace: Ireland

MOTHER
14. Maiden Name: --------
15. Birthplace: Ireland

16 (a) Informant: Mrs. Margaret D. Gilbert
(b) Address: 3306 N. Hilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears & Son
(b) Address: 805 N. Calvert Street

19 (a) ------ (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

AUG 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1946 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13-46 1946 to 8-21-46 1946 and that I last saw h[illegible] alive on 8-20-46 1946

Immediate cause of death: Cachexia + cardiac failure — Duration

Due to: Ca. of stomach

Due to: Secondaries to liver and carcinomatosis

Other Conditions: ------

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: ------

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: John F. Nogueira M.D.
Address: Md Gen Hosp Date signed 8/21/46

X

G43097 BC# D53238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √161c

G43097 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2735 Eastern Ave.
(c) Hospital or institution: Mercy Hospital 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (24) (If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Ciscle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-46

8. AGE: Years	Months	Days	If less than one day
			4 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sheridan Ciscle
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Ogle
15. Birthplace Balto. Md.

16 (a) Informant Sheridan Ciscle
(b) Address 2735 Eastern avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/46 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location

18 (a) Funeral director Chas J. Graner Son
(b) Address 118 W. Mt. Royal Ave

19 (a) (b)
AUG 22 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7 1946, at 4 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1946 to 8/7 1946, and that I last saw h~~er~~ alive on 8/7 1946

Immediate cause of death: Hyaline membrane disease

Due to: Rh incompatibility

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
5 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L Shuham M.D.
Address 11 E Chase Date signed 8/8/46

X

643098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 25-43098

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WREN LEE WELLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frederick B. Weller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1883

8. AGE: Years	Months	Days	If less than one day
62	11	26	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Frank Lee
13. Birthplace Canada

MOTHER 14. Maiden Name Isabelle Forsythe
15. Birthplace Va.

16 (a) Informant Mr. Fred B. Weller
(b) Address 1808 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8:23:46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20, 1946 at 9:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1946 to Aug. 20 1946 and that I last saw h.e. alive on Aug. 18 1946.

Immediate cause of death — Duration
Cancer of R.F. Breast
Due to
Due to
Other Conditions Metastasis to Spine

(Include pregnancy within 3 months of death)
Date of operation Radical Mast. 7/3
Major findings of operation: Carcinoma of Breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Simon Bragos M.D.
Address 1500 N. Charles St. Date signed 7/30/46

VS 150

G43099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/183

Registered No. G43095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 10 - 7 West St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 - Riggs Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arlie Eugene Keefer

3 (b) If veteran, name war: No. 1

3 (c) Social Security Account No. 214-05-2078

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Bertha M. Keefer (Nee Strupp)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1897

8. AGE: Years	Months	Days	If less than one day
48	8	9	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Route Supervisor
11. Industry or business Suburban Co. Beverage

FATHER
12. Name Willie Irvin Keefer
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Daisy Hoffman
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Bertha M. Keefer
(b) Address 2805 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 8/24/46 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1946, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 8/20/46 - 6:45 P.M. (Injured on 8/19/46)
(b) Where did injury occur? Jones Falls
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury [redacted]

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-21-46

Please write the causes of death clearly and legibly.

G43100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

G43100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1378 - Woodyear St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Richards

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	(Single) Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 17 1908

8. AGE: Years	Months	Days	If less than one day: hr.	min
38	4	2		

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Russell Richards
13. Birthplace South Carolina

MOTHER
14. Maiden Name (Rena) Kane
15. Birthplace South Carolina

16 (a) Informant Rena Richards
(b) Address 1378 Woodyear

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 | 23 | 46 (Month) (day) (year)
(c) Cemetery or crematory Spartanburg
Location Spartanburg - South Carolina

18 (a) Funeral director Lee H Nelson
(b) Address 1303 Presidman St

19 (a) AUG 22 1946 Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946 at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema.
Hypertrophy & Dilatation of Heart

Due to

Other Conditions Acute Alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mueller M.D.
Medical Examiner.
Date signed 8/20/46

G13101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH N 83a

Registered No. G13101

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age in especially important. Use ink, preferably, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Virginia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Virginia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Agnes Owen,

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Artamus V. Owen,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1879

8. AGE: Years	Months	Days	If less than one day
67	0	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name Frances P. McManus,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice Hughes
15. Birthplace Ireland,

16 (a) Informant Mr. Artamus V. Owen,
(b) Address 3016 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood,
Location Parkville, Md.

18 (a) Funeral director C. Vernon Zimmerman
(b) Address 4611 Park Heights Ave.

AUG 22 1946 Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Aug. 20, 1946, at 7.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946 to 8/20 1946, and that I last saw h[illegible] alive on 8/20 1946.

Immediate cause of death Cerebral hemorrhage — Duration 8/6/46
Due to Arterio Sclerosis — "
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. D. Bubert
Address 4803 Park Heights Date signed 8/21/46

G43102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G43102

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 370 + Monte Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-70
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 370 + Monte Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel H. Rauscher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Lena Rauscher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
78	1	21		

9. Birthplace Frederick Md. (Town, county, and state)
10. Usual Occupation Manufacturer
11. Industry or business

FATHER 12. Name Solomon Rauscher
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Trautman
15. Birthplace Germany

16 (a) Informant Mr. Sol Rauscher
(b) Address 370 + Monte Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harold Sonnenschein & Son
(b) Address 1902 Eutaw Place

19 (a) [illegible] Huntington Williams, Md.

AUG 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1946, at 11 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Aug 1946; and that I last saw him alive on 8/21 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 3 wks

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Wilson

Address 517 Pk. Ave. Date signed 8-24-46

Wilson

G43103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1214

Registered No. G43103

The entry item of information should be carefully supplied. Every item is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 + 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Eutaw Place. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE CASS CARY CAREY

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-2756

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1884

8. AGE: Years	Months	Days	If less than one day
61	10	17	hr. min.

9. Birthplace Missouri (Town, county, and state)

10. Usual Occupation Marine Engineer

11. Industry or business Maritime Service

FATHER
12. Name H. O. Cary
13. Birthplace Kentucky

MOTHER
14. Maiden Name Anna J. Knight
15. Birthplace Penna

16 (a) Informant Miss Mabel Cary
(b) Address 208 Walnut Ave. Canton, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 22 1946 (month) (day) (year)
(c) Cemetery or crematory Arlington Hill Cem.
Location Bangor, Me.

18 (a) Funeral director Wm. J. Fuchsen & Sons
(b) Address No. 7 Penna. Ave. - Balto. Md.

19 (a) AUG 22 1946 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 19 at 9:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Aug 21 1946, and that I last saw him alive on Aug 20 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Hypertensive cardiovascular renal disease	
Due to Myocardial insufficiency (Coronary occlusion)	
Other Conditions Acute pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Shorofsky M.D.
Address 601 N. Monroe St. Date signed 8/21/46

(over)

G43104 G43104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1/21a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl J. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John D. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1890

8. AGE: Years 51 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Lewis
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Margaret
15. Birthplace Calvert Co Md

16 (a) Informant Columbus Thomas
(b) Address 806 McKean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS AUG 22 19 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1946, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Aug 20 1946, and that I last saw h alive on Aug 20 1946.

Immediate cause of death (a) Hypertension
Cardio Renal Disease 6 Mos

Due to

Due to

Other Conditions Uremic Coma 2 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Williams M. D.
Address 6004 Arlington Ave

G43105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 c

Registered No. G43105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 - N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Logan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1911

8. AGE: Years 35 | Months | Days | If less than one day: hr. min.

9. Birthplace Greenville, S.C. (Town, county, and state)

10. Usual Occupation Clothing Presser

11. Industry or business

FATHER
12. Name Luther Dogan
13. Birthplace Greenville S.C.

MOTHER
14. Maiden Name May Puriton
15. Birthplace Greenville S.C.

16 (a) Informant Luther Dogan
(b) Address 1025 W. Fayette st.

17 (a) Shipped (burial, cremation, or removal) (b) Date thereof Aug 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenville
Location S. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 N. Schroeder St.

19 (a) (b) (Signature of registrar) Registrar

AUG 22 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946, at 10:10 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH - Coronary occlusion
Hypertrophy + dilatation of heart,
Edema + congestion of lungs,
Due to chr. glomerulo nephritis
acute congestion of liver
Other Conditions + kidneys

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry J. Mueller M.D.
Medical Examiner.
Date signed 8/19/46

G43106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82a

G43106 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2805 Edgecomb Circle
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Edgecomb Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH MOSZNER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director LORING BYERS
(b) Address 5005 Park Heights Ave

19 (a) [illegible] (b) Huntington Williams, M.D.
AUG 22 1946 Registrar

VS 191

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 22, 1946, at 9:25 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage,
Arteriosclerosis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed

G43107 BCH G43864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V157B

Registered No. G43107

Every item of information should be carefully supplied. Do not abbreviate. WRITE WITH UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 452 Illchester Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 452 Illchester Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BARBARA LYNN VALIANT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1946

8. AGE: Years	Months	Days	If less than one day
-	5	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Robert C. Valiant
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Margaret L. Gunther
15. Birthplace Baltimore, Co.

16 (a) Informant Mrs. Robert C. Valiant
(b) Address 452 Illchester Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Waverly, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 22 1946 (Signature of undertaker) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20, 1946, at 1:00a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 9 1946 to Aug 20 1946, and that I last saw her alive on July 24 1946.

Immediate cause of death: Circulatory failure — Duration

Due to Ruptured spina bifida

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred B. Smith M.D.
Address 11 E. Chase St. Date signed 8/22/46

X

043108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 043108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Granby St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1006 Granby St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H. Robosson

3 (b) If veteran, name war ✓ (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Talbert Robosson
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) March 2 1861.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	5	29		

9. Birthplace Beverly, W. Virginia (City, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph Hyndman
13. Birthplace West Va

MOTHER
14. Maiden Name Caroline Ruffle
15. Birthplace West Va

16 (a) Informant Joseph Robosson
(b) Address 16 Orms Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 1946 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows
Location Baltimore City Cumberland

18 (a) Funeral director Wendell Wagner
(b) Address 342 S Fulton Ave

19 (a) Registrar Huntington Williams, M.D.
(b) Date received AUG 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1946 at 4 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Aug 21 1946 and that I last saw h alive on Aug 21 1946

Immediate cause of death Malig neoplasm of Breast — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clifton F. Solomon
Address 129 S Broadway Date signed 8/22/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G43109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

Registered No. G43109

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important. PRINTING WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Walker ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Elizabeth DeBaugh.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-26-1646

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles T. DeBaugh

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1890

8. AGE: Years 56 | Months | Days 3 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Benj Franklin DeBaugh
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Theresa Emma Gray
15. Birthplace Balto. Co. Md.

16 (a) Informant Thomas DeBaugh
(b) Address 5 Walker ave. Pikesville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23. 46 (month) (day) (year)
(c) Cemetery or crematory Hart Chapel
Location Pikesville. Md

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville. Maryland

19 (a) AUG 22 1946 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1946, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1946, to 8-20 1946 and that I last saw her alive on 8-20 1946

Immediate cause of death: Cerebral embolus ??

Due to Auricular fibrillation

Due to —

Other Conditions Hyperthyroidism

(Include pregnancy within 3 months of death)

Date of operation 8-19-46

Major findings of operation: Diffuse hyperplasia of thyroid

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Gerald A. Martin
Address University Hosp. Date signed 8-20-46 (M. D.)

VS 150

G43110 BALTIMORE CITY HEALTH DEPARTMENT G43110

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 1401 HOMESTEAD St.
(c) Hospital or institution:
9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs, 4mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 HOMESTEAD St (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED GEORGE SPARKES

3 (b) If veteran, name war —

3 (c) Social Security Account No. 107-07-6725

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife RUTH HANCOCK SPARKES

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) DEC. 24th 1899

8. AGE: Years 46 | Months 7 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace SIBLYS COVE, NEWFOUNDLAND
(Town, county, and state)

10. Usual Occupation CONSTRUCTION SUPERINTENDENT

11. Industry or business BUILDING

FATHER
12. Name AUGUSTUS SPARKES
13. Birthplace SIBLYS COVE, NEWFOUNDLAND

MOTHER
14. Maiden Name MAGGIE BROWN
15. Birthplace SIBLYS COVE, NEWFOUNDLAND

16 (a) Informant MRS. Ruth H. SPARKES
(b) Address 1401 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2002 Orleans St.

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 23 1946

• MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/1946 19 at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 15 1943 to 8/19 1946. and that I last saw h/M alive on 8/19 1946.

Immediate cause of death PULMONARY TUBERCULOSIS — Duration 4 yrs

Due to ...

Due to ...

Other Conditions ...
(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operations ...

... of autopsy ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature John H. Hirschfeld M.D.
Address 6919 HARFORD Rd Date signed 8/19/1946

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT IN PENCIL, WITH UNFADING INK.

G43111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G43111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimare General
(c) Hospital or institution: Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Baltemare Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E D Spruance St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Selocete Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Percy Smith.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	24	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Geo. R. Vaider
13. Birthplace Virginia

MOTHER
14. Maiden Name Cox
15. Birthplace Virginia

16 (a) Informant Percy B. Smith
(b) Address 610 E. St. (19)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St.

19 (a) (Date rec'd by registrar) AUG 23 1946 (b) Huntington Williams, M.D. Place

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1946, at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1946 to Aug 20 1946, and that I last saw h alive on 3:55 P.M. Aug 20 1946.

Immediate cause of death Respiratory failure — Duration

Due to Cerebral Hemorrhage following fall.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Aug 18 at 3:05 A M
(c) Where did injury occur? 610 E. St Spruance St
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? NO
(Specify type of place)
(e) Means of injury Fell down Stairs

23. Signature E. L. Barnard M. D.
Place West Balt Gen Hosp Date signed Aug 20 46

For R. J. R. Davis, by Howard T. Maddux, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The USE INDELIBLE WRITING INK.

G43112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G43112 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1145 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James McClain Whittington

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife May 13-1884
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
57	3	4	hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Whittington
13. Birthplace Md.

MOTHER
14. Maiden Name Emmaline Nicholden
15. Birthplace Md

16 (a) Informant Emma Duggen
(b) Address 1145 N. Carrollton Ave

17 (a) Burial (b) Date thereof 8-26-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto. Co.

18 (a) Funeral director Saml. W. Thrasher Son
(b) Address 628 N. Gilmor St.

19 (a) AUG 23 1946 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1946, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to Aug 22 1946, and that I last saw him alive on Aug 22 1946.

Immediate cause of death: Cardiac Insufficiency
Disease

Duration
8 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M.D.
Address 1151 N. Carrollton Ave Date signed 8/22/46

G43133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G43133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2817 Lanvale Ave
(c) Hospital or institution: 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Lanvale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Babcock Bonsir

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: none

4. Race: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dorothy
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Aug 2 1863

8. AGE: Years 83 | Months 0 | Days 19 | If less than one day: hr. min.

9. Birthplace New York N.Y.
(Town, county, and state)

10. Usual Occupation Actor
11. Industry or business

FATHER
12. Name Unknown Bonsir
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Dorothy Bonsir
(b) Address 2817 Lanvale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkwood Md

18 (a) Funeral director Wilson & Dye
(b) Address 1214 Eutaw St

AUG 23 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1946 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1946 to 8/21 1946 and that I last saw h/m alive on 8/16 1946.

Immediate cause of death: Uremia — Duration: 1 week

Due to: Generalized Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Townsend Jr. M. D.
Address 14 E. Eager St Date signed 8/21/46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43114 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 432 — Registered No. G43114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Carolin
(c) Hospital or Institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Wilmot Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Barbara Rebbert REBBERT

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced (married)

6 (b) Name of husband or wife Herman R Rebbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/21/85

8. AGE: Years 61 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER — 12. Name Philip Holthaus
13. Birthplace Baltimore Md
MOTHER — 14. Maiden Name Margaret Ahlis
15. Birthplace Baltimore Md

16 (a) Informant Mr Herman J Rebbert
(b) Address 1114 Wilmot Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26/1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Road

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 23 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1946 to 8/22 1946. and that I last saw h ER alive on 8/22 1946.

Immediate cause of death — Duration
Uremia
Due to Nephritis
Due to
Other Conditions Diabetes (Etiology) (Autopsy)

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Turner M.D.
Address St. Joseph's Hospital signed 8/23/46

X

Print. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43115 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution: Edgewood Avenue 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Inglewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE JOYCE

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Harry S. JOYCE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1860

8. AGE: Years	Months	Days	If less than one day hr.	min.
86	2	5		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Burkert
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemeter
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, I C.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 23 1946 (Date received by local registrar) (b) [illegible] Wilk

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1946 at 11.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1946 to Aug 20 1946, and that I last saw her alive on Aug 20 1946

Immediate cause of death

	Duration
Edema Lungs-	2 days
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. Gill Hall M. D.
1631 E North Av Date signed Aug 21-46

X

VS 150

The correct age is especially important. Physicians: please give every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

G43116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G-43116
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1901 E. 30th Street
(c) Hospital or institution: a-b
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 E. 30th. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA GEHRING

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Otto Gehring
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) August 2, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Maddox
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Dr. Otto Gehring
(b) Address 1901 E. 30th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 23 1946 (Date received by registrar) (b) Huntington Woods, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1946 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1946. to Aug 20 1946. and that I last saw h[illegible] alive on Aug 18 1946.

Immediate cause of death Myocarditis — Duration 10 days
Due to Arterio Sclerosis — 5 yrs.
Due to Edema of Extremities
Other Conditions
(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Otto Gehring
Address 2358 Harford Date signed 8/21/46 M. D.

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any blank or omission of information should be carefully supplied. The

HEALTH DEPARTMENT—CITY OF BALTIMORE

G43117 CERTIFICATE OF DEATH 370 G43117

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 E. 23rd St. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 63 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Mrs. (MARY COATH KNAUER) U. S. Veteran Specify WAR

(a) Residence: No. 1937 E. 31st St., 12th Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female | 4. Color or Race: White | 5. Single, Married, Widowed, or Divorced (write the word): Married

6. If married, widowed, or divorced: HUSBAND of (or) WIFE of Mr. George Knauer.

6. DATE OF BIRTH (month, day, year): Sept. 24, 1882

7. AGE: Years 63 yrs | Months 10 | Days 27 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Baltimore.

FATHER

13. NAME: William Coath

14. BIRTHPLACE (city or town) (State or country): Baltimore

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT: Mr. George Knauer

(Address): 1937 E. 31st Street

18. BURIAL, CREMATION, OR REMOVAL

Place: Loudon Pk. Cem. Date: Aug. 24, 46

19. UNDERTAKER: HENRY SANDER & SONS, INC.

(Address): NORTH AVE. & BROADWAY

20. FILED: AUG 23 1946

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): August 21, 1946

22. I HEREBY CERTIFY, That I attended deceased from June 28, 1946 to Aug 21, 1946

I last saw h[illegible] alive on Aug 21, 1946 Death is said to have occurred on the date stated above, at 4:20 P.M.

The principal cause of death and related causes of importance were as follows:

	Duration of exact
(a) Lethargic Encephalitis	3 mos

Other contributory causes of importance: Pulmonary Edema | 3 days

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify —

(Signed) Nathaniel M Rask M. D.

(Address) 1002 E. 23rd St.

OCCUPATION is very important. See instructions on back of certificate.

VS 3

Huntington Williams, Md

X

643118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 643118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Gibbons Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Gibbons Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Allen D. Condiff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-1873

8. AGE: Years	Months	Days	If less than one day
73	1	8	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Griffin Condiff
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Hettie O. Hart
(b) Address 2702 Gibbons Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto. Md.

18 (a) Funeral director L. Rugh
(b) Address 3305 Harford Rd.

19 (a) (Date received by registrar) Hampton Williams, Registrar

AUG 23 1946

VS 101

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22nd 1946 at 9:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8/22/46

Dr Peake
4500 Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

S-43119
94a G43119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5503 Pilgrim Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5503 Pilgrim Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J Hill

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 12, 1875
8. AGE: Years 71 Months 5 Days 5 If less than one day hr. min.
9. Birthplace Snow Hill Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Emily
15. Birthplace Md.

16 (a) Informant Mr. James P. Hanna
(b) Address 5503 Pilgrim Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Leonard J. Peake
(b) Address 5205 Harford Rd
Huntington Williams, M.D.
Registrar

19 (a) AUG 23 1946
Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1946 est. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1946 to 8-22 1946 and that I last saw h alive on 8-16-1946.

Immediate cause of death
Coronary Thrombosis — Duration 6 Days
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4518 Harford Rd Date signed 8-29-46

X

correct age is especially important. Physicians; please write the

VS 150

643120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

643120
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 Ridgetop Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8-17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Walbrook (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Ridgetop Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary N. GRAY

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-0906.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	married.

6 (b) Name of husband ~~wife~~ William Z GRAY JR.
6 (c) If alive, give age 31. years

7. Birth date of deceased (mo., day, yr.) Feb 13 - 1913.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
33	6	9		

9. Birthplace ~~Baltimore~~ Wakefield Mass.
(Town, county, or state)
10. Usual Occupation housewife.
11. Industry or business

FATHER
12. Name LOUIS GEITKA.
13. Birthplace Poland.

MOTHER
14. Maiden Name ELIZABETH BRULINSKI
15. Birthplace Poland

16 (a) Informant Mrs Elizabeth GEITKA.
(b) Address 1232 Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-46 (month) (day) (year)
(c) Cemetery or crematory ST STANISLAUS.
Location Balto md.

18 (a) Funeral director George A Weber.
(b) Address 705 S Grin st

19 (a) AUG 22 1946 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22nd 1946, at 9.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1946 to 8/22 1946, and that I last saw her alive on 8/21 1946.

Immediate cause of death: Uremia — Duration: 3 days
Due to: Hypertensive Cardio Vasc-Renal Disease. — 12 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Kallina M.D.
Address 1845 N. Wolfe St Date signed 8/23/46

G43121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46 F

G43121 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Morstein

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Segelis
15. Birthplace Russia

16 (a) Informant Kate Schwartzman
(b) Address 2024 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-46 (month) (day) (year)
(c) Cemetery or crematory Washington Blvd
Location Washington Blvd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) AUG 23 1946 (b) Huntington Williamson (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23 1946, at 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to 8/23 1946, and that I last saw him alive on 8/23 1946.

Immediate cause of death: Carcinoma of Hard Palate with Generalized Metastasis — Duration 8 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gustave Cooper M. D.
Address 2201 Eutaw Place Date signed 8/23/46

VS 180

G43122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G43122
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 W Conway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 W Conway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lutishe Griffin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 - 1892

8. AGE: Years	Months	Days	If less than one day
53 54	10	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Rufus German
13. Birthplace md

MOTHER
14. Maiden Name Lutishe German
15. Birthplace md

16 (a) Informant Ella Griffin
(b) Address 526 W Conway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-46 (month) (day) (year)
(c) Cemetery or crematory Oldfield
Location Cambridge, Md

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Montgomery St

19 (a) (Date received by Registrar) AUG 28 1946 (b) Registrar Huntington Hillsdale, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1946, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1946 to 8/20 1946
and that I last saw h alive on 8/20 1946.

Immediate cause of death Coronary Thrombosis — Duration 1 hr
Due to Hypertension
Due to Diabetes Mellitus
Other Conditions Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alan A Lafond M. D.
Address 822 N. Broad St Date signed 8/27/46

LAFAYETTE

X

G43123

AB-99619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G43123

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos. 20days
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 E. Lombard st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gentry Underwood

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4- 1881

8. AGE: Years	Months	Days	If less than one day
65	4	17	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Underwood (D
13. Birthplace Va.

MOTHER
14. Maiden Name Millie Bunney (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24, 46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave

19 (a) (Date received by local registrar) (b) AUG 28 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21- 1946, at 9.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1- 1946, to 8-21 1946, and that I last saw him alive on 8-21 1946.

Immediate cause of death: Pulmonary tuberculosis, bilateral, far advanced — Duration

Due to

Due to

Other Conditions Arteriosclerotic Cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nancy E. McMillan
Address City Hospital Date signed 8/22/46
M. D.

X

G43124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V1639

Registered No. G43124

Please write plainly with pen and ink. Use no abbreviations. Make entries of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-1
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jones Royster

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 42 | Months | Days | If less than one day: hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Jones
13. Birthplace N. C.

MOTHER
14. Maiden Name Minnie Yancy
15. Birthplace N. C.

16 (a) Informant Edward Royster
(b) Address 504 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) AUG 23 1946 (Date rec'd by registrar) (b) Transcribed from Multigraphed Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1946, at 6:50 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chemical poisoning (Lye)
Acute gastritis
Due to Cloudy swelling of organs
Hypertrophy & dilatation of heart
Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/17/46 at about 2 P. M.
(b) Where did injury occur? 504 N Eden St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Swallowed Lye

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 8/18/46

X

G43125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 B

Registered No. G43125

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Dukeland
(c) Hospital or institution West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 W. Garrison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Herman A. Frank

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1913

8. AGE: Years	Months	Days	If less than one day
33 yrs	1	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Louis M. Frank
13. Birthplace Russia

MOTHER
14. Maiden Name Lena S. Landsman
15. Birthplace Russia

16 (a) Informant Isidor Frank
(b) Address 2820 W. Garrison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cemt.
Location Bowleys Lane

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1126 W. North Ave.

19 (a) AUG 23 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 August 1946 at 9:48 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1946 to 22 Aug 1946 and that I last saw h[illegible] alive on 22 Aug. 1946

Immediate cause of death	Duration
Hypertensive (110.2)	
Due to Subacute Bacterial Endocarditis.	
Due to Rheumatic C.V. Dis	
Other Conditions Mitral Stenosis & Insuff. Aortic Insufficiency Chronic Interstitial Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify industrial place)
(e) Means of injury
23. Signature
Address West Baltimore Gen Hosp. Date signed 8/23/46 M. D.

VS 150

G43126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 651 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 651 George (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett E. Gaines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Robert Gaines

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1883

8. AGE: Years 62 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Kent Island Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Benjamin Frazier

13. Birthplace Md

MOTHER 14. Maiden Name Louise ?

15. Birthplace Md

16 (a) Informant Hattie Cornish

(b) Address 651 George St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem:

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 3229 W. Lombard St

19 (a) Aug 23 1946 (b) Huntington Williams Registrar

AUG 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1946 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1942 to 8-21 1946 and that I last saw h[illegible] alive on 8-15 1946.

Immediate cause of death: Hypertension / Cardio Sclerosis — Duration 1 yr.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Atwell Jones M.D.

Address 5 E. 39 Gt Date signed 8-22-46

VS 150

G43127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183a

Registered No. G43127

Please answer every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 814 Harlem Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Herbert Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	negro	Widower

6 (b) Name of husband or wife Alberta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	14	hr. min.

9. Birthplace Md.
(City, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Edward Fletcher
13. Birthplace Prince George Co. Md

MOTHER
14. Maiden Name Mary Bowser
15. Birthplace Mitchellville, Md

16 (a) Informant Charles Fletcher
(b) Address 814 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25-46 (month) (day) (year)

(c) Cemetery or crematory Western Blue Mem
Location

18 (a) Funeral director Mrs Katie P. Williams
(b) Address 922 N. Eutaw St.

19 (a) AUG 23 1946 Huntington Williams
(Date accepted by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1946 at 8 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1946 to Aug 20 1946 and that I last saw h[illegible] alive on Aug 18 1946.

Immediate cause of death	Duration
Coronal Thrombosis	3 wks
Due to Arteriosclerosis (Primary)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Banfield
[illegible] N. Fulton Ave
Date signed 8/22/46 M.D.

VS 180

G43128

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83 B

G43128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 393 Evesham Ave.
(c) Hospital or institution:

27-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 393 Evesham Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE M. EAST

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Barnis B. W. East
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1862

8. AGE: Years	Months	Days	If less than one day hr.	min.
83	11	29		

9. Birthplace Howard Co., Md. (Town, county, and state)
10. Usual Occupation --
11. Industry or business --

FATHER
12. Name Otha Tucker
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Hipsley
15. Birthplace Md.

16 (a) Informant Mrs. John W. Donaldson
(b) Address 2647 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) AUG 23 1946 (Registered by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1946 to Aug 21 1946 and that I last saw him alive on Aug 20th 46.

Immediate cause of death	Duration
Cerebral Thrombosis	2 mo.
Due to Cerebral arteriosclerosis	1 yr.
Due to Senility	10 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. H. Chaffee M. D.
Address 6210 York Rd Date signed Aug 22 1946

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] of information should be carefully supplied. The

AB-1447

G43129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43129 Registered No. 938

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10yrs- 7 mos- 20days
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, give RURAL address or town)
(d) Street No. 1228 N. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Stevens (Stephens)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March ?- 1892

8. AGE: Years	Months	Days	If less than one day
54	5	?	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Duckin (D
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Cook (D
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pressman

19 (a) AUG 23 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1946, at 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12- 31- 1935 to 8-21- 1946, and that I last saw h er alive on 8-21- 1946.

Immediate cause of death Cephalomalacia + Cerebral arteriosclerosis

Duration

Due to Hypertension + Arterio-sclerotic C.V. Disease

Due to

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto. City Hosps Date signed 8-27-46

correct age is especially important. Physicians: please write the

G43130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G43130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L Devine

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of ~~husband or wife~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name PATRICK DEVINE
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY KANE
15. Birthplace IRELAND

16 (a) Informant JAMES F. KAVANAGH M.D
(b) Address 3328 McELDERRY ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road
18 (a) Funeral director John C Myers
(b) Address 3600 E Baltimore St
19 AUG 23 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1946 at 7.P. M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1944 to AUG 20 1946, and that I last saw HER alive on AUG 20 1946.

	Duration
Immediate cause of death ARTERIOSCLEROSIS	10 YRS.
Due to CHR. INT NEPH	3 YRS
Due to	
Other Conditions MYOCARDITIS	3 YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F. Kavanagh M.D.
Address 3328 McElderry Date signed 8-23-46

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... information should be carefully supplied. The

G43131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G43184

Please answer all questions; use of information should be carefully supplied. The accuracy of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Not come

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town South Glenburnie, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4th Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ethel L. Newton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fred. F. Newton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1898

8. AGE: Years 47 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, or state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George F. Ruth
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Shipper
15. Birthplace Maryland

16 (a) Informant Mr. Fred. F. Newton
(b) Address 4th Ave. Glenburnie Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26, 1946 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location GLEN BURNIE, Md

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md

19 (a) Filed AUG 23 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1946 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Aug 22 1946, and that I last saw h[illegible] alive on Aug 22 1946.

Immediate cause of death	Duration
Cardiac Resp Failure	
Due to Congestive Heart Failure	9 mos.
Due to Rheumatic Heart Disease E	"
Other Conditions Mitral Stenosis Auricular fibrillation	"

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Connor M. D.
Address Mercy Hosp Date signed 8-22-46

G43132

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G43132
Registered No.

Please write clearly and legibly. Use ink or typewriter. Do not fold. Do not write outside the lines. If the space provided is insufficient for any item, add a sheet of paper and identify the item.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-W
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael S. Hart

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26. 1879

8. AGE: Years	Months	Days	If less than one day
66	7	25	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William H. Hart
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ann Kelly
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. William Hart
(b) Address 102 W. 24th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Chas. J. Eggnet Sons
(b) Address 118 W. Mt. Royal Ave
(Signature) Huntington Williams, M.D.
Registrar

19 AUG 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21-1946 at 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 8-21-46

VS 151

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. 043133

043133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 536 S. Bentalou St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Ashton ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Wilhelmia Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1874

8. AGE: Years 72 | Months 6 | Days 16 | If less than one day — hr. — min.

9. Birthplace Baltimore Md. (town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

FATHER
12. Name August Koslowski
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Rose Brown
(b) Address 536 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director J. B. Hoffmeister Son
(b) Address 300 Eutaw Place

19 (a) (Date and hr. received by registrar) AUG 23 1946 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1946, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Aug 21 1946, and that I last saw her alive on Aug. 21 1946.

Immediate cause of death: Coronary Thrombosis — Duration 10-15 Min.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Alfred Cole M. D.
Address 1934 Wilkins Ave Date signed Aug 24, 1946

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any error or information should be carefully supplied. The

G43134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G43134 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Mt. Pleasant Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6-8
(e) Length of stay in Baltimore (yrs., mos., or days) About 41yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Mt. Pleasant Ave. (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No) If yes, name country

3 (a) FULL NAME MAX F. KUHN

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 213-07-9474

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary A. Kuhn
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) August 24, 1894.

8. AGE: Years	Months	Days	If less than one day
51	11	28	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Mill-Wright
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Loyos Kuhn
13. Birthplace Hungary

MOTHER
14. Maiden Name Bertha Gottshall
15. Birthplace Hungary

16 (a) Informant Mary A. Kuhn (Widow)
(b) Address 3909 Mt. Pleasant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-46. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location 7225 Eastern Ave.

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Fait Ave.
(c) Date of burial (year) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1946 at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1945, to Aug 22 1946, and that I last saw him alive on Aug 22 1946

Immediate cause of death	Duration
Carcinoma R lung & Pleura	10 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jany 11-1946
Major findings of operation Carcinoma R lung & pleura
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Clift
Address 5010 Greenleaf Road Date signed 8-28-46

VS 190

G43135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G43135

Please write in ink. Spelling of information should be carefully supplied. The accuracy of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 N. Milton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Rohm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John Rohm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1885

8. AGE: Years	Months	Days	If less than one day
61 yrs.	7	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Conroy
15. Birthplace Ireland

16 (a) Informant John Rohm, Husband
(b) Address 806 N. Milton Avenue

17 (a) Burial (b) Date thereof 8/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Date received AUG 23 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1946, at 2 21 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1943, to Aug 21 1946, and that I last saw h. alive on Aug 20 1946.

Immediate cause of death Cerebral hemorrhage. Arteriosclerosis - paralysis — Duration 1 week ?

Due to Hypertension — Duration at least 15 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Klemes, M. D.
Address 2623 E. Monument Date signed 8/24/46

G43136

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1108

G43136
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Crawford Retreat 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 E. Monument Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John Bernard Schutte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife Goldie Sinnett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4, 1885

8. AGE: Years 61 yrs. | Months 4 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Photographer

11. Industry or business Own Business

FATHER
12. Name Henry B. Schutte
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Eve Werner
15. Birthplace York, Pa.

16 (a) Informant Mamie Schutte
(b) Address 731 N. Lakewood Avenue

17 (a) Burial (b) Date thereof 8/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) AUG 23 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1946, at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1946, to Aug. 21, 1946, and that I last saw him alive on Aug. 21 1946.

Immediate cause of death Chronic Myocarditis — Duration

Due to

Due to

Other Conditions Lobar Pneumonia — 5 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel B. Wolfe, M.D.
Address 331 E. Chase St. Date signed 8-23-46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G43137
Registered No.

Please write clearly and legibly. Use ink or typewriter. Do not use pencil. If the cause of death is unknown, so state.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D of A
(b) Street address 1611 N. Broadway
(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (JOHN SANDERSON) John Sanderson

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower.
6 (b) Name of husband or wife: Jane Oliver
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 15 1859

8. AGE: Years 87 | Months 5 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John Sanderson
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Boud
15. Birthplace Baltimore Md.

16 (a) Informant Miss Isabelle U. Sanderson
(b) Address 1611 N. Broadway (day Hr)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24 42 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co.

18 (a) Funeral director Stewart Mayne Co.
(b) Address 108 W Mt Royal.

19 (a) AUG 28 1942 (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1942 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic CVD
Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. L. Sulmonetti M.D.
Medical Examiner.
Date signed 8/24/42

G43138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G43138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Kenwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. Wesbrook Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Stuart (Louise Belcher Stuart)
3 (b) If veteran, name war none
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Glen Stuart
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) March 10 1888
8. AGE: Years 58 Months 5 Days 12 (If less than one day hr. min.)
9. Birthplace Brooklyn N.Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none
FATHER 12. Name Louis Belcher
13. Birthplace New York State
MOTHER 14. Maiden Name Esther Bagot
15. Birthplace New York State
16 (a) Informant Mrs Mary S. Foutz (daughter)
(b) Address Ruxton, Md.
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug 24/46 (month) (day) (year)
(c) Cemetery or crematory Garrett Mount
Location Baltimore
18 (a) Funeral director Stewart Morgan Co
(b) Address 108 W North Ave
19 (a) (Date received by registrar) AUG 23 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1946, at 2 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1946 to 8-22 1946, and that I last saw her alive on 8-22 1946.

Immediate cause of death	Duration
Respiratory arrest	
Due to Cerebral softening	
Due to Infarction	
Other Conditions Mitral stenosis & auricular fibrillation	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Mitral stenosis - Cerebral softening

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. L. Crouch, M.D.
Address University Hosp. Date signed 8-22-46 M. D.

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 043139

043139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard Co
(c) City or town Woodstock
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislava Siczko

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-1-1890

8. AGE: Years 56 | Months 3 | Days 21 | If less than one day [redacted] hr. [redacted] min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Peter Siczko
13. Birthplace Stocko, Poland

MOTHER
14. Maiden Name Petronilla Wnuk
15. Birthplace Krlko, Poland

16 (a) Informant Records Seton Institute
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-46 (month) (day) (year)
(c) Cemetery or crematory Woodstock College
Location Woodstock, College

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 1018 W. Mosher Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 23 1946

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 August 1946, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1927, to Aug 22 1946, and that I last saw him alive on Aug 22 1946.

Immediate cause of death: Diabetes Mellitus / Bovine heart with anasarca — Duration: 1 year

Due to

Due to

Other Conditions: Dementia Praecox, Paranoid Type

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard P. Hayes M. D.
Address Seton Institute Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G43140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43140 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3031 Remmington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Remmington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Flaherty

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15-1878

8. AGE: Years	Months	Days	If less than one day
67	9	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Flaherty
13. Birthplace Ireland

MOTHER
14. Maiden Name Don't know
15. Birthplace

16 (a) Informant Miss Nellie Kearney
(b) Address 3031 Remmington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory New Cath. Balto Md
Location

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Baltimore St

19 AUG 23 1946 (Date received by local reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1946 at 2 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/ /1946 to 8/22 1946 and that I last saw h[illegible] alive on 8/16 1946

Immediate cause of death: Coronary Occlusion — Duration —
Due to arterio Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 2020 E. Chase M.D. Date signed 8/23/46

VS 150

G43141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No. G43141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Jarrettsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Burton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife Clarence E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-1902

8. AGE: Years	Months	Days	If less than one day
43	9	8	hr. min.

9. Birthplace Rocks Harford Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Knopp
13. Birthplace Md

MOTHER
14. Maiden Name Grace Boyd
15. Birthplace Md

16 (a) Informant Clarence E. Burton
(b) Address Jarrettsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 1946 (month) (day) (year)
(c) Cemetery or crematory Mrs Mathes Mem
Location Loyalton Harford Co Md

18 (a) Funeral director Charles E. Hunt
(b) Address Jarrettsville Md

19 (Registrar) AUG 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1946, at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1946, to 8/23 1946, and that I last saw her alive on 8/23 1946.

Immediate cause of death: Resp. failure — Duration

Due to: Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8/21/46

Major findings of operation: Prob. astroblastoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosby M. D.
Address Univ. Hosp Date signed 8/24/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G43142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6200 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 6200 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Hayes Grimes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: James F. Grimes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1877

8. AGE: Years 68 | Months 7 | Days 27 | If less than one day hs. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Patrick Hayes
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Dunn
15. Birthplace Ireland

16 (a) Informant Mrs. Agnes Hayes Russell
(b) Address 6200 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Fred. Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) AUG 2 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1946 at 9:29 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 46.
and that I last saw h er alive on Aug 19 1946.
Immediate cause of death July 27 Dr. Hill
Carcinoma of intestines

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: None

Duration: 1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas H. Stone M.D. M. D.
Address 2919 St. Paul St. Date signed

Please type or print all information. Physicians: please write the causes of death clearly and legibly.

G43143 Howard X 139b 135B G43143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital, Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (Rural) Texas (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Belle Howard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William W.

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 14, 1882

8. AGE: Years	Months	Days	If less than one day
64	1	9	hr. min.

9. Birthplace Cockeysville, Balto. Co., Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Howard
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Hedrick
15. Birthplace Balto. Co. Md

16 (a) Informant Wm W. Howard
(b) Address Texas, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-46 (month) (day) (year)
(c) Cemetery or crematory Gessops Methodist
Location Sparks Md.

18 (a) Funeral director J. Scott Brooks
(b) Address Sparks, Md.

AUG 23 1946 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1946, at 8 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1946 to Aug. 23 1946, and that I last saw her alive on Aug 22 1946.

Immediate cause of death: Massive Pulmonary Embolism — Duration

Due to Pelvic thrombosis

Due to Post-operative Venous Stasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-10-46

Major findings of operation: Uterine diseases Cystocele; Rectocele

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M.D.
Address University Hosp. Date signed 8/23/46

VS 150

Please answer all questions as completely as possible. Physicians: please write the cause of death clearly and legibly.

G13144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G13144

Type or print plainly with indelible pencil. Make no erasures or cross outs. Write out answers in full. Use black ink. Do not abbreviate. Fill in all blanks clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 East Henrietta St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 East Henrietta Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Captain White

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1870

8. AGE: Years 75 | Months 11 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Lewis Jones
13. Birthplace Md.

MOTHER
14. Maiden Name ? Raeder
15. Birthplace unknown

16 (a) Informant Mrs Pierson
(b) Address 315 Warren Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F Flemming Sons
(b) Address 716 Light St.

19 AUG 23 1946 (Date received by registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1946 at 1150A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mullis M.D.
Medical Examiner.
Date signed 8-22-46

G43145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G43145 Registered No.

Please answer questions or information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 E Valtimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marian Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	divorced

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1895

8. AGE: Years	Months	Days	If less than one day
51	X	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Bottlemace
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Holtz
15. Birthplace Md

16 (a) Informant George Bottlemace
(b) Address 3707 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 /46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

AUG 23 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1946, at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1946, to 8-21 1946, and that I last saw her alive on 8-21 1946.

Immediate cause of death Carcinoma of rectum — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-15-46 Colostomy
Major findings of operation: Carcinoma of rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Gould M. D.
Address 714 E Eastern Date signed 8-22-46

VS 150

G13146

CWK-103968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 122B

Registered No. G43146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove State Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29-1904

8. AGE: Years	Months	Days	If less than one day
42	3	24	hr. min.

9. Birthplace Stevensville-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Franklin Lewis
13. Birthplace ?

MOTHER
14. Maiden Name Mamie Lister
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Stevensville
Location Stevensville, Md.

18 (a) Funeral director C. L. Logue
(b) Address Church Hill, Md

19 AUG 24 1946 (Date rec'd by registrar) Huntingtown Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1946 to Aug. 23 1946, and that I last saw h er alive on Aug. 23 1946.

Immediate cause of death Laparotomy Postoperative — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 22 Aug 46

Major findings of operation: Intestinal obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry L. Ryder M. D.
Address Balto City Hosp Date signed 23 Aug.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use ink. If information should be carefully supplied. Use

G43147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G43147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 Berwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Berwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kratz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1871

8. AGE: Years	Months	Days	If less than one day
75	6	7516	hr. min.

9. Birthplace Balto. Co. Md
(Town, county, and state)

10. Usual Occupation Truck farmer

11. Industry or business

FATHER
12. Name John Kratz
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Haas
15. Birthplace Germany

16 (a) Informant Henry Kratz
(b) Address 2618 Berwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 24 46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Baltimore Rd Huntington Williamsie, Md

19 AUG 24 1946 (Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1946, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Aug. 1946 and that I last saw him alive on Aug. 21 1946.

Immediate cause of death Gastric hemorrhage — Duration

Due to Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 45

Major findings of operation Inoperable carcinoma of stomach

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Henry Haas M. D.

Address 4218 Highfield Rd Date signed Aug. 23 46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully ...

VS 190

643148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

643148

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 RAMSAY St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 RAMSAY St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THERESA C. HAYES

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife CHARLES W. HAYES

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 28-1892

8. AGE: Years 54 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

MOTHER / FATHER

12. Name JAMES HINES

13. Birthplace BALTO MD

14. Maiden Name MARY KELLEY

15. Birthplace BALTO MD

16 (a) Informant CHARLES W. HAYES

(b) Address 1409 RAMSAY St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof August 24 1946 (month) (day) (year)

(c) Cemetery or crematory MT OLIVET
Location BALTO MD

18 (a) Funeral director P. H. & B. M. WALTERS

(b) Address 847 W. Fayette St

19 (a) Filed AUG 24 1946 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1946; at 12 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1/46 19__ to 8/21/46, and that I last saw her alive on 8/20/46

Immediate cause of death	Duration
Acute cardiac dilatation	2 hrs.
Due to Angina pectoris	20 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Calas M. D.
Address 42 S. Fulton Date signed

G43149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148

Registered No. G43149

Please write plainly. The information should be carefully supplied. The questions are especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Patterson Ave
(c) Hospital or institution: Sinai Hosp. of Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 St. Paul St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Charlene Felts G 50214

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leo Felts

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) May 2, 1913

8. AGE: Years	Months	Days	If less than one day
33	3	20	hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name C. H. Curtis
13. Birthplace Tennessee

MOTHER — 14. Maiden Name ?
15. Birthplace

16 (a) Informant Patient's Husband
(b) Address 925 St. Paul St

17 (a) (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Howard N. Bright Jr.
(b) Address 4914 Belair Road

19 (a) AUG 24 1946 Huntington Williams
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1946, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12, 1946, to Aug. 22, 1946, and that I last saw her alive on Aug 22, 1946.

Immediate cause of death: Chloroepithelioma — Duration ?

Due to Metastases to - Lungs, Liver, Spleen, Kidneys

Due to Intestines

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 17, 46

Major findings of operation: Appendectomy July 17, 1946

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Leo M. Seltzer Jr.
Address Sinai Hosp. Date signed 8/23/46 M. D.

PHYSICIAN — Underline the cause to which death should be charged statistically.

VS 150

643150 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 643150

CERTIFICATE OF DEATH 47D

Registered No. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 230 S. Port ave - St., _____ Ward)
Length of residence in city or town where death occurred 59 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Gustav A.C. Voss — If U. S. Veteran specify WAR _____

(a) Residence: No. 230 S. Port ave St., _____ Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Lottie (nee Morton)

6. DATE OF BIRTH (month, day, year) 4/21/1885

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
61	4	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Machinist
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Copper Co.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER
13. NAME ? ?
14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER
15. MAIDEN NAME Amelia ?
16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Edward Voss - Son
(Address) 3207 Putty Hill Rd.

18. BURIAL, CREMATION, OR REMOVAL
Place St. Paul's Date 8/26, 1946

19. UNDERTAKER Lilly & Geiter Inc.
(Address) 1623 N. Howard St.

20. FILED AUG 24 1946 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) AUG. 22, 1946

22. I HEREBY CERTIFY, That I attended deceased from AUG. 20, 1946 to AUG. 22, 1946
I last saw him alive on AUG. 20, 1946 Death is said to have occurred on the date stated above, at 5:30 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
CARCINOMA RIGHT LUNG	5 MOS.
METASTASIS, GENERALIZED	4 MOS.

Other contributory causes of importance:

Was an operation performed? YES Date of APRIL 31, 1946
For what disease or injury? CARCINOMA OF LUNG (RT.)
Name of operation EXPLORATORY
What test confirmed diagnosis? BIOPSY Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19__
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place _____
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
NO If so, specify _____

(Signed) Benjamin Hyletani M. D.
(Address) 1215 S. HIGHLAND AVE.

V.S.

Instructions on back of certificate. See instructions at very important.

G43151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G43151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSAN GARRETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1870

8. AGE: Years	Months	Days	If less than one day
75		11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Nickerson Swann
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah Waters
15. Birthplace Md.

16 (a) Informant Mr. Wilbert Garrett
(b) Address 1105 Park Ave.

17 (a) Burial (b) Date thereof 8-26-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 AUG 24 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Aug. 21, 1946, at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1946 to Aug 21 1946 and that I last saw h[illegible] alive on [illegible] 1946.

	Duration
Immediate cause of death [illegible] Bronchopneumonia	10 days
Due to [illegible] Myocarditis	?
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8-24-46

G43152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G43152

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 47
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 649 W. Lafayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRWIN E. GARDNER - IRWIN EDGAR GARDNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-9258

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Grace Gardner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	14	hr. min.

9. Birthplace Eastern Shore Md.
(Town, county, and state)

10. Usual Occupation Electrician - Retired
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mary Robinson
(b) Address 649 W. Fayette St.

17 (a) Burial (b) Date thereof Aug. 24, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Dill Bros.
(b) Address 3109 Fredk. Ave.

19 (a) AUG 24 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 19 at 10:50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Huntington Williams M.D.
Medical Examiner.
Date signed 8/24/46

643153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 122 B

Registered No. 643153

Type or print with pen and ink. Information should be carefully supplied. Space 4a is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Hooper ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter B. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-0504

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Beulah E. Brooks
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Feb. 10 1883

8. AGE: Years	Months	Days	If less than one day
63	6	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Paper hitter
11. Industry or business

FATHER
12. Name George Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Beulah E. Brooks.
(b) Address 3610 Hooper Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location

18 (a) Funeral director Clarence R. Sampson
(b) Address 3615-17 Gleston Ave

19 (a) AUG 24 1946 (Date rec'd by registrar) (b) Huntington Williams, Md. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Aug. 1946 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1946, to 8/23 1946, and that I last saw him alive on 8/23 1946.

Immediate cause of death: Pulmonary edema — Duration 10 hrs.
Due to: [redacted] Heart failure.
Due to:
Other Conditions: Uremia; Nephritis
7 & 9 months pregnancy (Include pregnancy within 3 months of death)
Date of operation 8/9/46
Major findings of operation: 7 months pregnancy; Uremia; Acute Nephritis
Autopsy? Yes & Addison.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Smith
Address Md. Gen. Hosp. Date signed 8/25/46

VS 150

G43154
AB-93572

BALTIMORE CITY HEALTH DEPARTMENT / 107
CERTIFICATE OF DEATH

G43154
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 3mos- 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Asbury Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Sleeger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19- 1874

8. AGE: Years	Months	Days	If less than one day
72	5	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Sleeger
13. Birthplace Pa.

MOTHER
14. Maiden Name Caroline Kissinger
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug 24/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Clemmer & Bonorden
(b) Address 3616-17 Chestnut Ave

19 AUG 24 1946 Huntington Williams
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1946, at 7.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1946, to 8-22- 1946 and that I last saw h. 1m alive on 8-22- 1946.

Immediate cause of death
Bronchopneumonia
Renal failure

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Hydronephrosis, Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norvyl Waldron M. D.
Address B C H. Date signed Aug 24/46

VS 150

G43155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G43155

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 York Rd (If rural, give location)
(e) Citizen of foreign country? Greece (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Spanakos

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Stella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1890

8. AGE: Years	Months	Days	If less than one day
56	—	—	hr. min.

9. Birthplace Sparta, Greece (Town, county, and state)
10. Usual Occupation Restaurateur
11. Industry or business

FATHER
12. Name Konstasios Spanakos
13. Birthplace Greece

MOTHER
14. Maiden Name Maria Phelia
15. Birthplace Greece

16 (a) Informant George Stavropoulos
(b) Address 3500 Edondale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Wolfe Burke Bradley
(b) Address 1922 W. North Avenue

19 AUG. 24, 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1946. at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1946. to Aug 22 1946. and that I last saw him alive on Aug 22 1946.

Immediate cause of death Resp. failure

Duration 9 days

Due to Uremia

Due to Chr. Glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Richard J. Cross M. D.
Address University Hosp Date signed 8/22/46

VS 150

G43156 AB-103750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43156 Registered No.

Type or use ink. Information should be carefully supplied; please write the causes of death clearly and legibly. Physicians: please report as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Avon Beach Road-Dundalk (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Shelton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Jeanette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1902

8. AGE: Years	Months	Days	If less than one day
44	1	15	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Shelton
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Stanley Ave

19 AUG 24 1946 (Date received by registrar) Huntington Williams, M. D.

VS-190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19- 1946, at 8.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1946, to 8-19 1946, and that I last saw him alive on 8-19- 1946.

Immediate cause of death	Duration
Malignant abscesses	2 weeks
Due to Pyuemia pneumonia	2 weeks
Due to Bronchiectasis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Rowell McPherson M. D.
Address Baltimore City Hosp Date signed 28 Aug 46

G43157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

G43157 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3045 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KENNETH Earl STOWELL

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1934

8. AGE: Years 12 | Months 7 | Days 13 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation --

11. Industry or business --

FATHER
12. Name Carl J. Stowell
13. Birthplace Md.

MOTHER
14. Maiden Name Florence M. Fitzsimmons
15. Birthplace Connecticut

16 (a) Informant Mrs. Florence Stowell
(b) Address 3045 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/46 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd Cem.
Location Ellicott City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 24 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946, at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Broken neck, Broken back, Fractured Skull

Due to

Other Conditions Lacerations, bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 20-6

(a) Date of injury 8-21-46 at 5 P. M.

(b) Where did injury occur? Gwynn Falls Quarry (Bank - Balto. Street

(c) Did injury occur at home, on farm, industrial place, in public place? Private Property While at work? No

(d) Means of injury While playing near bank fell into quarry

23. Signature [illegible] M.D. Medical Examiner.

Date signed 7-23-46

VS 191

G43158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 C

Registered No. G43158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Wayne Ave #7 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Myrtle Smith Key

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: William R. Key
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1890

8. AGE: Years	Months	Days	If less than one day
55	11	24	hr. min.

9. Birthplace: William R. Key (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Thomas Smith
13. Birthplace: England

MOTHER
14. Maiden Name: Lena Millemann
15. Birthplace: Alsaac-Lorraine

16 (a) Informant: Mr. William R. Key
(b) Address: 2906 Wayne Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/25/46 (month) (day) (year)
(c) Cemetery or crematory Ft. Wayne
Location: Ft. Wayne, Ind.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by registrar AUG 24 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1946 at 5.02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16-1946 to 8-22-1946 and that I last saw h alive on 8-22-1946.

Immediate cause of death: Cardiac Collapse. — Duration

Due to: Cardiac Decompensation

Due to

Other Conditions: Pneumonia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Agusta M. D.
Address Md General Hosp. Date signed 8/22/46

VS 150

G43159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G43159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Jane Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Elliot eJames Wilson
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) JAN. 2, 1894

8. AGE: Years	Months	Days	If less than one day
52	7	18	hr. min.

9. Birthplace Sappark County, Bishopville, S.C.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Edmond Green
13. Birthplace South Carolina

MOTHER
14. Maiden Name Tisha Fisher
15. Birthplace South Carolina

16 (a) Informant Elliot James Wilson
(b) Address 2510 Madison Ave

17 (a) Burial (b) Date thereof Aug. 24, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rebuter Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs Lenny M. Holland
(b) Address 1631 Druid Hill Ave.

AUG 24 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1946. to Aug 20 1946.
and that I last saw her alive on Aug 19 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Congestive Heart Failure	
Due to Arterio sclerotic Heart Disease & Cardiac Enlargement	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Arteriosclerosis & Failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2340 Madison Ave Date signed 8-21-46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43160 BC# F82260 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 10 G43160 Registered No.

Please write the causes of death clearly and legibly. Physicians: please be especially careful that information should be correct, as it is important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~[illegible]~~ Loyola Loyola Blvd. & Loyola Rd.
(c) Hospital or institution: Lydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 West Henry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Harold Elliott Jr.

3 (b) If veteran, name war —

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1943

8. AGE: Years	Months	Days	If less than one day
3	.	12	. hr. . min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business —

FATHER 12. Name Harold Elliott Sr.
13. Birthplace Maryland

MOTHER 14. Maiden Name Virginia Lehman
15. Birthplace Maryland

16 (a) Informant parents
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (mo.) Aug 23 (day) 46 (year)
(c) Cemetery or crematory Glen Haven.
Location

18 (a) Funeral director Joseph Kaufmann
(b) Address 608 Edmondson Ave

19 (a) (Date rec'd by local reg.) AUG 24 1946 (b) Huntington Williams, M.D.

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1946, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1946, to Aug 23 1946, and that I last saw him alive on Aug 23 1946.

Immediate cause of death	Duration
Terminal pneumonia	
Due to Diphtheria, tracheal, laryngeal, tonsillar	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Byron G. Gleason M. D.
Address Lydenham Hosp. Date signed

G43161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

Registered No. G43161

HB #19894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7 22
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1240 S. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Mary Simnoski or Mary Simminski or Maryanna Sibiski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Michael(d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 6, 1873

8. AGE: Years 73 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Rec
(b) Address 4940 Eastern Ave.

17 [illegible] Date thereof Aug 29/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Md

18 (a) Funeral director Hoffman Southworth
(b) Address 1004 N. Kenwood Ave

19 AUG 24 1946 Huntington Wilson Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1936 to Aug. 23, 1946 and that I last saw h[illegible] alive on Aug. 23 1946.

Immediate cause of death: Cerebro-Vascular accident.

Due to: interioscleotic C-V Disease.

Due to:

Other Conditions: Ca. of Can. Bron Bronchopneumonia.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Herbert R. Fowler M. D.
Address Balto. City Hosps Date signed 8-24-46

93 D

PHYSICIAN

Underline the cause to which death should be charged statistically.

G43162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43162 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 Sanford Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 539 Sanford Place (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cassie Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife Casino Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1887

8. AGE: Years	Months	Days	If less than one day
59	3	12	hr. min.

9. Birthplace Morefield Co. W. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sanford Bryce
13. Birthplace Williamsport W. Va.

MOTHER
14. Maiden Name Rebecca Redman
15. Birthplace Williamsport W. Va.

16 (a) Informant Kelsey Thompson
(b) Address 539 Sanford Place

17 (a) Burial (b) Date thereof Aug. 24, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 AUG 24 1946 Huntington Williams, M.D. Address 1131 Hollins St. Date signed 8/26/46
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1946; at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1946 to 8/22 1946 and that I last saw it alive on 8/22 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Left Sided Paralysis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard Comer, D. Address 1131 Hollins St. Date signed 8/26/46

VS 150

G43163 AB-103934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46M

G43163 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 35 or 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Inez G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- 1880 (65 ?

8. AGE: Years 66? Months ? Days ? If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business City Water Department

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 24 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22- 1946, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1946 to 8-22 1946, and that I last saw him alive on 8-22- 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Bronchopneumonia	
Due to Carcinoma of the Gastro-Intestinal Tract	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R. Yearborough M. D.
Address Balto. City Hosp. Date signed 8-23-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The name, date of birth, and residence of informant should be carefully supplied.

VS 150

643164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

✓ Registered No. 643164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 N. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUTHER BACON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1906

8. AGE: Years 40 | Months 4 | Days 20 | If less than one day: hr. min.

9. Birthplace Bloometown, Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name William Bacon
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Murdock
15. Birthplace Unknown

16 (a) Informant Bishop Bacon
(b) Address 314 N. Poppleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 1946 (month) (day) (year)
(c) Cemetery or crematory W. M. Auburn Cem
Location

18 (a) Funeral director Mrs Katie P. Williams
(b) Address 822 N. Schroeder St

1946 AUG 24 (Date rec'd by Local Reg.) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1946, at 7:35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
2nd & 3rd degree burns
Due to covering 85% of body surface

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-21-46 at 11.25 P. M. 18-1
(b) Where did injury occur? Stable--rear of 940 W. Saratoga St.
(c) Did injury occur at home, on farm, industrial place, in public place? Matchman - Stable While at work? Yes
(d) Means of injury Stable conflagration

23. Signature Howard J. Mackie M.D.
Medical Examiner.
Date signed 8-22-46

G43165 ✓ X G43165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

Please answer all questions. Any error or omission should be carefully supplied. The information is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Green Sts.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Shadrack H. Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
About 83			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Cooper
13. Birthplace Md.

MOTHER
14. Maiden Name Dianna Kemp.
15. Birthplace Md.

16 (a) Informant Ernest Cooper
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/46 (month) (day) (year)
(c) Cemetery or crematory Gray
Location Balto Co Md

18 (a) Funeral director Edw Shipton
(b) Address Hampstead Md

G 9 (a) 5 1946 (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24-1946, at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1946 to 8-24 1946, and that I last saw him alive on 8/24 1946

Immediate cause of death Cardiac failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8-22-46
Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Carey M. D.
Address Univ Hosp Date signed 8/24/46

G43166 BALTIMORE CITY HEALTH DEPARTMENT G43166

CERTIFICATE OF DEATH 93D

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G43167 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43167

CERTIFICATE OF DEATH 55E

Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. Physicians: please give this matter your personal attention. Questions are especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.,
(c) Hospital or institution: U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 109 days
(e) Length of stay in Baltimore (yrs., mos., or days) 109 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County --
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 James Street, New York (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME MC CURRY, John Francis

3 (b) If veteran, name war

3 (c) Social Security Account No. 071-12-5978

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1880

8. AGE: Years	Months	Days	If less than one day
65	9	3	hr. min.

9. Birthplace Brooklyn, N.Y. (Town, county, and state)
10. Usual Occupation Steward
11. Industry or business Seafaring

FATHER
12. Name James McCurry
13. Birthplace Cushendall, Ireland

MOTHER
14. Maiden Name Mary McFaul
15. Birthplace Cushendall, Ireland

16 (a) Informant Records
(b) Address U.S.Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-46 (month) (day) (year)
(c) Cemetery or crematory Madonna Cem. Location Ft Lee New Jersey
18 (a) Funeral director Oder Funeral Boyle Inc
(b) Address 4644 York Road Baltimore, Md.
19 8-25-1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24th, 1946 at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17th 1946 to Aug. 24th 1946, and that I last saw him alive on Aug. 24th, 1946.

Immediate cause of death Carcinoma metastatic, primary unknown. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Southworth M. D.
Address Marine Hosp. Date signed 8/24/46

VS 150

X

G43168

BALTIMORE CITY HEALTH DEPARTMENT G43168

CERTIFICATE OF DEATH 157E

Registered No.

The information must be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Miss (b) County
(c) City or town Meridian (If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 State Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecile Dobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-41

8. AGE: Years 5 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Miss (town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Wendell Dobbs

13. Birthplace Miss

MOTHER 14. Maiden Name Mary Crawford

15. Birthplace Miss

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27 46 (month) (day) (year)

(c) Cemetery or crematory

Location Greenlawn Memorial Park

18 (a) Funeral director John F. Stallings Jr.

(b) Address 1900 Eutaw Place

49 (a) AUG 25 1946 (Date rec'd by registrar) Arlington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1946 at 1:35 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 21 1946 to Aug 24 1946 and that I last saw him alive on Aug 24 1946.

Immediate cause of death Cerebral failure — Duration

Due to Hemorrhage

Due to Operation for Patent Ductus Arteriosus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 24 1946

Major findings of operation: Patent Ductus Arteriosus

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry F. Bahnsen M.D.

Address Johns Hopkins Hospital Date signed 8/24/46

VS 150

G43169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G43169 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. Please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Robbins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Bradshaw

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	white	married

6 (b) Name of husband or wife Virginia Murphy
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Jan. 8 1921

8. AGE: Years	Months	Days	If less than one day
24 25	7	13	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Phillips Packing Co.

FATHER
12. Name Noble F. Bradshaw
13. Birthplace Md.

MOTHER
14. Maiden Name Daisy Hurley
15. Birthplace Md.

16 (a) Informant Mrs. Blandy Bradshaw
(b) Address Cambridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/46 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Methodist Cem
Location E. Cambridge, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address Cambridge Md.

AUG 25 1946

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1946. at 2 42 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1946 to Aug 21 1946, and that I last saw him alive on Aug 21 1946.

Immediate cause of death Uremia — Duration

Due to Chronic glomerulonephritis

Due to Hypertension

Other Conditions Pulmonary Congestion

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Small contracted fibrous kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. McCurdy M. D.
Address University Hospital Date signed 8-21-46

VS 150

G43170 G43170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G43170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1211 Lighter
(b) Street address ~~6F18 Belclare Rd~~ 1211 Lighter
(c) Hospital or institution: S.B.G.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk - 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6F18 Belclare Rd
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Achilles Coatsolonia or Goccioloni

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-2629

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Julia

(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan. 17 1877

8. AGE: Years 69 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Motor Car Operator

11. Industry or business Bethlehem Steel Cor.

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Romain J. Coatsolonia
(b) Address 3818 Belclare Rd. Dundalck Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 26 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Arnold Della Rose
(b) Address 52 N. Morley St.

AUG 25 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1946 at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1946 to Aug 22 1946 and that I last saw him alive on Aug 22 1946.

Immediate cause of death: CARCINOMA with Generalized METASTASIS — Duration

Due to

Due to — Duration: OVER

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert F. Spindler M.D. M. D.

Address "3" Light St. Date signed 8/26/46
Co. Balto. Gen. Hosp.
Baltimore, Md.

G43171 BALTIMORE CITY HEALTH DEPARTMENT G43171
CERTIFICATE OF DEATH 65

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwoods Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W University Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Catherine Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Richard Jr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1912

8. AGE: Years	Months	Days	If less than one day
34	7	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Lawrence Fallon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Dempsey
15. Birthplace Harford Co Md

16 (a) Informant Richard Dorsey Jr
(b) Address 106 University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md

18 (a) Funeral director John C Mowan
(b) Address 3000 Baltimore St

19 (a) AUG 25 1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 16, 1946, to August 23 1946, and that I last saw h[illegible] alive on August 23, 1946

Immediate cause of death Respiratory Arrest

	Duration
Due to Chemical imbalance and mixed terminal anemia	
Due to Addison's disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Adrenal atrophy in. pernicious

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter L. Couch M. D.
Address University Hospital Date signed 8-23-46

G43172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G43172 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William P. CHARRINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Dorothea

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1893

8. AGE: Years	Months	Days	If less than one day
53 54	0	3	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation U. S. Army Officer

11. Industry or business

FATHER
12. Name James M. Charrington
13. Birthplace Ohio

MOTHER
14. Maiden Name Louisa Cook
15. Birthplace Ohio

16 (a) Informant Brother Henry Charrington
(b) Address Washington, D. C.

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** 8/26/46 (month) (day) (year)

(c) Cemetery or crematory Arlington National
Location Arlington, D. C.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 247 St. Paul St.

19 (a) AUG 25 1946 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/46 19 , at 6:30 p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Watts M.D.
Medical Examiner.
Date signed 8/25/46

HEALTH DEPARTMENT—CITY OF BALTIMORE

G43173 CERTIFICATE OF DEATH 1141 G43173

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N Milton Ave. Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Joseph F. Rockhold If U. S. Veteran specify WAR

(a) Residence: No. 424 N Milton Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Anna M Rockhold

6. DATE OF BIRTH (month, day, year) June 7 - 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	2	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME Charles Rockhold

14. BIRTHPLACE (city or town) (State or country) Scotland

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Anna M Rockhold
(Address) 424 N Milton Ave

18. BURIAL, CREMATION, OR REMOVAL Greenmount
Place Greenmount Date June 9 1946

19. UNDERTAKER Chas P Powell
(Address) 2427 Edmondson Ave

20. FILED JUN 25 1946 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) AUG. 24, 1946

22. I HEREBY CERTIFY, That I attended deceased from 17 AUG. 1946 to 24 AUG. 1946

I last saw him alive on AUG. 24, 1946 Death is said to have occurred on the date stated above, at 12:30 A.M.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
BRONCHIAL ASTHMA	34 YRS.
LUNG. ABSCESS RT.	9 MOS.

Other contributory causes of importance:

Was an operation performed? NO Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify.

(Signed) Benjamin Bijhelum M. D.

(Address) 121 S. HIGHLAND AVE.

W 5

X

G43174 BALTIMORE CITY HEALTH DEPARTMENT G43174
CERTIFICATE OF DEATH 1318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 N. Dallas
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 N. Dallas (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Lich
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Robert Lich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1876

8. AGE: Years 70 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Joel Hemsley
13. Birthplace
MOTHER 14. Maiden Name Catherine?
15. Birthplace

16 (a) Informant Grace Brooks
(b) Address 1736 N. Dallas

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md.

18 (a) Funeral director Mrs Pitts G. Elliott
(b) Address 429 N. Caroline St
AUG 26 1946

19 (a) (b) Wellington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1946 at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to Aug 23 1946 and that I last saw h[illegible] alive on Aug 23 1946

Immediate cause of death	Duration
Acute Myocarditis	1 day
Due to Chr. Nephritis	3
Due to Uraemia	2 days

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. L. Levy M. D.
Address 1420 E. Chase Date signed Aug 24 '46

VS 150

Write the causes of death clearly and legibly. Physicians: please write the cause which is especially important. Please answer all questions as carefully supplied.

G431175 BC# F42745 BALTIMORE CITY HEALTH DEPARTMENT 6 ✓ G431175 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Somerset St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Puckett ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1942 ✓

8. AGE: Years 4 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter Puckett

13. Birthplace

MOTHER 14. Maiden Name Catherine ?

15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem. a Co. Cemetery

Location

18 (a) Funeral director Mrs. Robt. Gelhot & Son

(b) Address 1629 N. Carrollton St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1946 at 11 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1946 to Aug 24 1946, and that I last saw him alive on Aug. 24 1946.

Immediate cause of death Acute fulminating Asymptomatic — Duration

Due to Meningococcus meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebrospinal meningitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Dorman M.D. M. D.

Address Johns Hopkins Hosp. Date signed 8/24/46

AUG 25 1946

VS 150

Physicians: please write the causes of death clearly and legibly. The

G43176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43176 Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 457 E. 23rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AVERY W. MOORE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Belle Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1876

8. AGE: Years	Months	Days	If less than one day
69	9		hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)
10. Usual Occupation Loader in steel Co
11. Industry or business Patterns Horse Co

FATHER
12. Name Samuel Moore
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah Ashburn
15. Birthplace Pa

16 (a) Informant Charles H. Moore
(b) Address 457 E 23rd St

17 (a) Burial (b) Date thereof 8/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md
18 (a) Funeral director Wilson & Poe
(b) Address Park Ave & Fort Ave
19 (a) Huntington Williams, Registrar
(Date rec'd by registrar)

AUG 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1946 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Fractured leg

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 8-17-46 at 9 P. 9-8 M.
(b) Where did injury occur? In front of 1918 Harford Avenue.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 8-24-46

VS 151

G43177 ✓ G43177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MILLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1885
8. AGE: Years 61 Months Days — If less than one day: hr. min.
9. Birthplace: Warrow Colorado
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Fred. Miller
(b) Address: 1035 Aliceanna St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/26/46 (month) (day) (year)
(c) Cemetery or crematory: H Homelows
Location: Baltimore Md
18 (a) Funeral director: Wilson & Thone
(b) Address: 2104 E Fort Ave
19 (a) 8-25-1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Shock

Due to 2nd - 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-23-46 at 3-2 P.M.
(b) Where did injury occur? 1535 Aliceanna St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Coffee due to water turned on burning coffee pot

23. Signature: Howard J. Mullen M.D.
Medical Examiner
Date signed 8-24-46

VS 191

643178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

643178 Registered No.

Please write clearly with ink. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & 33rd Sts.
(c) Hospital or institution: Home (Blackstone Apts.)
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 33rd & Charles Sts. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME Alma Miller Birdsey Porter

3 (b) If veteran, name war: None.
3 (c) Social Security Account No.: None.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Wm David Porter
6 (c) If alive, give age —
7. Birth date of deceased (mo., day, yr.): Aug 12 - 1855
8. AGE: Years 91 | Months 0 | Days 13 | If less than one day: hr. min.
9. Birthplace: Meriden - Connecticut (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: "

FATHER
12. Name: Linus Birdsey
13. Birthplace: Meriden - Conn.

MOTHER
14. Maiden Name: Vincy Ann Miller
15. Birthplace: New Haven - Conn.

16 (a) Informant: Miss Theora J. Bunnell (Niece)
(b) Address: Blackstone Apts. - City
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-46 (month) (day) (year)
(c) Cemetery or crematory: E. Main St. Cemetery
Location: Meriden - Conn.
18 (a) Funeral director: STEWART & MOWEN COMPANY (W. F. WOOLEN SUC.)
(b) Address: 108 N. North Ave.
19 (a) AUG 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946, at 9:00 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1946 to Aug. 25 1946 and that I last saw h[illegible] alive on August 24 1946.

	Duration
Immediate cause of death: Cardio-Respir. Artery Failure	
Due to: Arteriosclerotic Heart Disease	
Due to: Senile Psychosis Acute or Chronic Possible Carcinoma Stomach	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Newland Edward Day M. D.
Address: 4-E-33rd St - Balto. Date signed 8-25-46

VS 150

X

G43179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

G43179 Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. Physicians: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis C. Blair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1872

8. AGE: Years	Months	Days	If less than one day
74	6	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name John Blair
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah Wissel
15. Birthplace Baltimore Md

16 (a) Informant Elizabeth V Blair
(b) Address 1315 W. Lombard St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/27/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 911-13 Hollins St.

19 (a) Huntington Williams, M.D. Registrar

Aug 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24th 1946, at 4a M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Aug 1946, to 23 Aug 1946, and that I last saw him alive on 23 Aug 1946.

Immediate cause of death	Duration
Acute Cardiac failure	24 hrs.
Due to Bronchogenic Carcinoma	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Tommasello M.D. M. D.
Address 910 W. Lombard St Date signed 24 Aug 46.

J Tommasello

G43180 filed BALTIMORE CITY HEALTH DEPARTMENT G43180
CERTIFICATE OF DEATH 160 C Registered No.

Please write the causes of death clearly and legibly. Physicians: please supply information requested. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon'a Boulevard Dickman St. Balt 30
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. Foot of Dickman St. Balt (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 23 Aug '46

8. AGE: Years	Months	Days	If less than one day
—			hr. — min. 1

9. Birthplace Foot of Dickman St. Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Ernest Gorden Moore
13. Birthplace Lynchburg, Virginia.

MOTHER
14. Maiden Name Josephine Ms Quade
15. Birthplace Fort Monroe, Va.

16 (a) Informant Josephine Moore
(b) Address 2nd Dickman St. Balto 30.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2930 Pulaski Road

18 (a) Funeral director John J. Cannon & Son
(b) Address 940-43 Fallsway St.

19 (a) AUG 26 1946 Burington, N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Aug 1946, at 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— to — 19—, and that I last saw h— alive on — 19—.

Immediate cause of death	Duration
Asphyxia	
Due to aspiration blood & mucous	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Gorden M. D.
Address South Balt. Gen'l Hosp Date signed 23 Aug '46

VS. 150

G43181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43D

G43181
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as carefully as information should be carefully supplied. The especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 E. 37th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert A. Adams

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 218-03-7383

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary Justus Adams
6 (c) If dead, give age 54 years

7. Birth date of deceased (mo., day, yr.) 4/17/82

8. AGE: Years 64 | Months 4 | Days 5 | If less than one day: hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)

10. Usual Occupation Balto. Transit Co.

11. Industry or business

FATHER
12. Name Emery Adams
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mrs Mary Adams.
(b) Address 912 E. 37th Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Av. & Broadway

19 (a) (Date received by Registrar) AUG 26 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1946, at 7:11¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1946 to 8/22 1946, and that I last saw him alive on 8/21 1946.

Immediate cause of death: Acute Cardiac Failure — Duration

Due to: Myocarditis (Chronic)

Due to: Hypertension & Glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature H. Jaworsky
Address 4 So Wolfe St. Date signed 8/22 1946

G43182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1930

G43182
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Fareckson Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Fareckson Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID RAYSEY SHANNON

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary V. McClaskey Shannon
6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1882

8. AGE: Years: 63 | Months: 8 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: City of Baltimore
11. Industry or business:

FATHER
12. Name: Francis Shannon
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Anna Norris
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Mary V. Shannon
(b) Address: 1303 Fareckson Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 26 1946 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1946 at 10.10 A. M. P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1946 to Aug. 22 1946.
and that I last saw him alive on Aug 21 1946.

Immediate cause of death: myocarditis (Chron.)
Due to: Arterio sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 2 / ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury:

23. Signature: Eugene A. Casam Jnr M. D.
Address: 5101 Downing Lane Date signed 8/27/46

VS 150

Registered

G43183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G43183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton Ave.
(c) Hospital or institution:
N. M. Carroll Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY F. JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Earl Carroll
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace ?

16 (a) Informant Miss Rosa Stewart
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-26-1946 (month) (day) (year)
(c) Cemetery or crematory Holmes Town
Location Tourneck Hill Co. Md

18 (a) Funeral director Wm A Francis A. Hennelly
(b) Address 578 W Biddle St

AUG 26 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1946, at 10:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946, to Aug. 2 1946, and that I last saw h[illegible] alive on Aug 2, 1946.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular disease	1 yr
Due to Generalized arteriosclerosis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris, Jr. M. D.
Address 1824 W. Franklin St. Date signed 8-25-46

VS 190 Huntington Williams, M.D.

Instructions to undertakers: Physicians: please write the causes of death clearly and legibly. Answers to questions should be carefully supplied. The information is especially important.

G43184
BB 9/10/2005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G43184

Please write plainly. Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 62 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Hughes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Edward Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1884

8. AGE: Years	Months	Days	If less than one day
62	6	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stanley Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Mammie Deal
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Arlington Ave.
19 (a) Date received AUG 26 1946 Registrar M. D.
(b) Address Huntingtown Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1946, at 9:53 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1946 to Aug. 23, 1946, and that I last saw her alive on Aug. 23, 1946.

Immediate cause of death	Duration
Due to Cerebral Hemorrhage	1 day
Due to Hypertensive Cardiovascular Disease	3 years
Other Conditions Diabetes Mellitus	3 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. Raymond Huffington M. D.
Address Baltimore City Hosp Date signed 24 Aug 46

X

B 43185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46A

B 43185
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write carefully, supplying important omissions promptly. etc.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Abottson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 6 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Abottson
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Huthmer

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-0012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Catherine M.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 9/22/1884

8. AGE: Years	Months	Days	If less than one day
61	11	2	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name Joseph Huthmer
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Ayel
15. Birthplace

16 (a) Informant Catherine M
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave.

18 (a) Funeral director L.J. Rack
(b) Address

19 (a) 8/26/46 (Huntington Williams Mortuary)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1946, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1946, to August 24 1946 and that I last saw him alive on Aug. 24 1946.

Immediate cause of death Carcinoma of oesophagus — Duration 6 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Lachman M. D.
Address 322 Calhoun Apts Date signed Aug 26, 1946

VS 150

b43186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

b43186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis C Klingenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Gertrude B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1883

8. AGE: Years	Months	Days	If less than one day
63	6	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Police Lieutenant

11. Industry or business

FATHER
12. Name Adam A. Klingenberg
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Masak
15. Birthplace Europe

16 (a) Informant Mrs. Alice Schaefer
(b) Address 3514 Frankford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/46 19 at 10:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weems M.D.
Medical Examiner.
Date signed 8/24/46

VS 151

B 43187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

B 43187 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town RFD 13 Balto 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Albertina Shivers ALBERTINA SHIVERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife Emmanuel V. Shivers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1875

8. AGE: Years	Months	Days	If less than one day
71	1	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Lavender
13. Birthplace Md.

MOTHER
14. Maiden Name Albertina ?
15. Birthplace Md.

16 (a) Informant Mr. William J. Moxley
(b) Address Cape May Beach, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-46 (month) (day) (year)
(c) Cemetery or crematory Oaklwan
Location Baltimore,

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Aug 23 1946, and that I last saw h[illegible] alive on Aug 23 1946.

Immediate cause of death	Resp. failure	Duration
Due to	Asphyxiation by C-V liquor	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard J. Crom M. D.
Address University Hosp Date signed 8/23/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Please answer all questions. If information should be carefully supplied. The

B43188
O.C.#-54772

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

A43188 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caretaker's Apartment
(c) Hospital or institution:
St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Park drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald L. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1946

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Newborn Baby

11. Industry or business

FATHER 12. Name Donald J. Anderson
13. Birthplace Md.

MOTHER 14. Maiden Name Marian V. Thompson
15. Birthplace Md.

16 (a) Informant Mrs. Donald Anderson
(b) Address 1404 Park drive

17 (a) Burial (b) Date thereof 7-26-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morland
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1946, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1946, to Aug. 25 1946, and that I last saw h[illegible] alive on Aug. 25 1946

Immediate cause of death Cardio respiratory Failure
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
over

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Wells M.D.
Address 20 E. Mt. Vernon Pl. Date signed 8-26-46

VS 150

X

Instructions: Information should be carefully supplied. The cause of age is especially important. Physicians: please write the causes of death clearly and legibly.

G43189

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 47 D

G43189 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The answers to questions must be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland Aves.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. ~~Md.~~ (b) County
(c) City or town ~~Baltimore~~ PHILADELPHIA (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Lindsay
3 (b) If veteran, name war --
3 (c) Social Security Account No. --
4. Sex M
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 11, 1885
8. AGE: Years 61 Months 2 Days 14 If less than one day hr. min.
9. Birthplace Philadelphia Pennsylvania (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Charles R. Lindsay
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Margaret Wallace
15. Birthplace Phila., Pa.

16 (a) Informant Mrs. Margaret Vogsted
(b) Address ? PHILADELPHIA, PA.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/26/46 (month) (day) (year)
(c) Cemetery or crematory Fernwood
Location Philadelphia, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by local registrar) AUG 26 1946 (b) Burying Permit No. 8

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946 at 9:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1946 to Aug 25 1946 and that I last saw him alive on Aug 24 1946

Immediate cause of death Tracheal Obstruction — Duration 3½ mos

Due to Primary Epidermoid Bronchogenic Carcinoma of the Lung

Due to

Other Conditions Multiple Lung Abscesses

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Carcinoma of Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Dubrinsky M. D.
Address West Balto. Sem. Bldg. Date signed Aug 26 1946

G43190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

Registered No. G43190

Please write the causes of death clearly and legibly. The information should be carefully supplied. The physician is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 E. 22nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIOLA BENNETT HOLLAND

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Laurence J. Holland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1898

8. AGE: Years	Months	Days	If less than one day
48	4	3	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Milton Bennett
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Mammie Shipley
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. J. Peel
(b) Address 21 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 26 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1946, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Unk 1945 to Aug 25 1946 and that I last saw h[illegible] alive on Aug 23 1946.

Immediate cause of death: Cancer of the Pancreas — Duration: 1 year

Due to

Due to

Other Conditions: 0

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. N. Pearce M. D.
Address 405 N. Chas Date signed Aug 26/46

VS 150

G43191 — G43191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4018 Deepwood Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4018 Deepwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pamelia Bacon Sudler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife John Morling Sudler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1858

8. AGE: Years	Months	Days	If less than one day
87	11	10	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Bacon
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Pamelia Cole
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Elizabeth S. Kirk
(b) Address 4018 Deepwood Road

17 (a) Burial (b) Date thereof 8/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sudlersville
Location Sudlersville, Md.

18 (a) Funeral director John O. Mitchell Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Aug 24 1946, and that I last saw her alive on Aug 24 1946

Immediate cause of death Cancer bladder — Duration 2½ years

Due to

Due to

Other Conditions Senile

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H Pearce M. D.
Address 2105 N. Charles St. Date signed

VS 150 AUG 26 1946

Correct as to especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G43182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

G43182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home 12-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Capt. William J. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lillian Bruce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-1860

8. AGE: Years	Months	Days	If less than one day
85	11	24	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation See Captain

11. Industry or business

FATHER
12. Name William Joseph Bond
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Melisa Fletcher
15. Birthplace Va

16 (a) Informant Mrs. Lillian B. Bond
(b) Address 2735 N. Chas. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemy
Location Balto. Md

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) AUG 26 1946 (Date received by registrar) Thurlington for Williams Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24-46 19 , to 8-24-46 19 , and that I last saw h im alive on 8-24-46 19

Immediate cause of death	Duration
Cardiac dilatation	
Due to Fractured hip	
Due to Old Age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 12-6
(b) Date of occurrence 2-24-46 at M
(c) Where did injury occur? home
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? 2735 N. Chas. St While at work?
(Specify type of place)
(e) Means of injury fell down on floor

23. Signature Howard C. Blake, M. D.
Address 422 Med. Arts Date signed 8-26-46

Howard J. Wallace, M. D.

G43193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G43193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1325 W Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel W. Jordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-95

8. AGE: Years	Months	Days	If less than one day
50	8	29	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Jordon
13. Birthplace Va

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Va

16 (a) Informant Relative
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/46 (month) (day) (year)
(c) Cemetery or crematory Northumberland
Location Northumberland Co. Va

18 (a) Funeral director Wes. L. Nelson
(b) Address 1308 Freeman St

19 (a) (Date received by local registrar) (b) Registrar

AUG 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1946 at 3:30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug 24 1946 and that I last saw him alive on Aug 24 1946.

Immediate cause of death Gastric hemorrhage — Duration 2 mos

Due to Lymphosarcoma

Due to

Other Conditions Bleeding bronchiectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Tarry brain content present in nodes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmond L Dubois M. D.
Address Johns Hopkins Hospital Date signed 8-27-46

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G43194 BALTIMORE CITY HEALTH DEPARTMENT G43194
CERTIFICATE OF DEATH 93D
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3627 Rexmere Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Hiss Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie K Rich

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry C Rich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/68

8. AGE: Years 77 | Months 7 | Days 26 27 | If less than one day hr. min.

9. Birthplace State Massachusetts
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John H Emerson
13. Birthplace State New Hampshire

MOTHER
14. Maiden Name Susan Bragg
15. Birthplace State Maine

16 (a) Informant Albert Rich
(b) Address 3010 Hiss Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director Lasahur Funeral Home
(b) Address 7401 Belair Rd Balto 6 Md

19 (a) Filed by (b) Registrar
1946
VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/46 19 6:30 AM, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to true death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Harris M.D.
Medical Examiner.
Date signed 8/25/46 X

G43195

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194A

G43195 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1202 Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Levin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1851

8. AGE: Years 95 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Ellis Levin
(b) Address 1091 N Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-46 (month) (day) (year)
(c) Cemetery or crematory Location Hebrew Herring Hun Inc

18 (a) Funeral director Jack Levin Inc
(b) Address 1398 E Baltimore St

19 (a) 8-26-1946 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1946, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1946, to 8-26 1946 and that I last saw h alive on 8-26 1946.

Immediate cause of death: Coronary thrombosis
Due to: hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Levin
Address Levindale Date signed 8/27/46

VS 190

X

G43196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G43196 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TAMMORO SIMON WITCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife Isador
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name LAIB
13. Birthplace RUSSIA

MOTHER
14. Maiden Name RACHAEL
15. Birthplace RUSSIA

16 (a) Informant MRS. R. EPSTEIN
(b) Address 2531 BOARMAN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-26-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Point Rd.
Location Mt. Point Rd.

18 (a) Funeral director Park Lewis Inc
(b) Address 1439 E. Balto St

26 (a) 1946 (b) Arlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946, at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 25 1946, to Aug 25 1946, and that I last saw he alive on Aug 25 1946.

Immediate cause of death Cardiac failure
Pulmonary Edema

Due to Hypertensive Arterio-sclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Rosenman M. D.
Address Sinai Hospital Date signed 8/27/46

VS 150

Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G43197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G43197
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Clarks Lane, Bare Hills
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Clarks Lane, Bare Hills
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES H. FENWICK

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age 1878

7. Birth date of deceased (mo., day, yr.) July 9, [illegible]

8. AGE: Years 68 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Charles Co. Md/
(Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER 12. Name John W. Fenwick
13. Birthplace Maryland

MOTHER 14. Maiden Name Sally Dyson
15. Birthplace St. Mar'y Co. Md.

16 (a) Informant Mary E. Fenwick
(b) Address Clarks Lane, Bare Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hobland
(b) Address 1631 Druid Hill Avenue, Md

AUG 26 1946
(Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1946 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1946 to Aug. 23 1946 and that I last saw h im alive on Aug. 23 1946

Immediate cause of death: Congestive Heart Failure — Duration: 2 Month

Due to Hypertension — Unknown

Due to

Other Conditions Diabetis Mellitus — Unk.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Geo. H. McDonald M. D.
Address 844 N. Carey Street Date signed 8/24/46

VS 150

Physicians: please write the causes of death clearly and legibly. The [illegible] carefully supplied. The [illegible] especially important.

G43198 — BALTIMORE CITY HEALTH DEPARTMENT — G43198 Registered No.

CERTIFICATE OF DEATH 93E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward Apts. Whitelock & Brookfield
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Edward Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL HAAS.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie R. Haas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1853

8. AGE: Years 93 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Munich. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name ? Haas,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown,
15. Birthplace Germany.

16 (a) Informant Mrs. Lillie R. Haas,
(b) Address Edward Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Goodstein & Son
(b) Address 1902 Eutaw Place.

19 (a) (b) Registrar

AUG 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25th. 1946 at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1946 to 8/25 1946 and that I last saw h[illegible] alive on 8/24 1946.

Immediate cause of death: Myocardial insufficiency — Duration 2 days
Due to Arteriosclerosis — ?
Due to Senility. — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter, M.D.
Address Garrison & Windsor Date signed 8/26/46

VS 150

Please answer all questions carefully and legibly. Physicians: please write the causes of death clearly and legibly.

G43199 — 4329 — G43199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46 G

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 N Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 N Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E Doon

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 217-12-7491A

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A Doon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1871

8. AGE: Years 75 | Months 7 | Days 17 | If less than one day: hr. min.

9. Birthplace London England (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name John Doon

13. Birthplace England

MOTHER — 14. Maiden Name Rhoda Miller

15. Birthplace England

16 (a) Informant Mary A Doon

(b) Address 1234 Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/46 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Baltimore Md

18 (a) Funeral director William J Doe

(b) Address 219 S K. Town St

AUG 26 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1946 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1946 to Aug 25 1946 and that I last saw him alive on Aug 25 1946.

Immediate cause of death Carcinoma pancreas — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis R. Mason

Address 4327 Park Heights Ave Date signed 8/22/46

G43200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V93D

Registered No. G43200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S. Montford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Miesenbeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Married

6 (b) Name of husband or wife Gregor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11-1890

8. AGE: Years	Months	Days	If less than one day
55	8	13	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name August Guldan
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa -?
15. Birthplace Germany

16 (a) Informant Mrs. Mary Miesenbeck
(b) Address 618 S. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorman Mill Rd

18 (a) Funeral director Lilly & Zerbe
(b) Address 403 S. Wolfe Street

19 (a) (b)

AUG 26 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1946 to August 1946 and that I last saw her alive on Aug. 24 1946.

Immediate cause of death: Cardio vascular hypertensive disease — Duration: years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak, M.D.

Address 408 S. Patt. Ob-Gyn. Date signed 8/25/46

643201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 643201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN S. Gaeng

3 (b) If veteran, name war World War-2

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1915

8. AGE: Years 31 Months 30 Days 7 If less than one day hr. min. 22

9. Birthplace St Louis - Mo
(Town, county, and state)

10. Usual Occupation Lamal Operator

11. Industry or business Sullivan Lamed Co.

FATHER
12. Name John Joseph Gaeng
13. Birthplace St. Louis Mo

MOTHER
14. Maiden Name O'Toole
15. Birthplace St Lou Mo.

16 (a) Informant Elizabeth Gaeng Wife
(b) Address 310 S. Beatty St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/27/46 (month) (day) (year)

(c) Cemetery or crematory Balto National
Location Frederick Road

18 (a) Funeral director Lilly & Zahn
(b) Address 4913 Eastern Ave

AUG 26 1946

19 (a) (Date rec'd by registrar) **(b)** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946, at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-23-46 at 4 A.M. 2-3
(b) Where did injury occur? Aboard the "A. D. Johnson" (Specific location)
(c) Did injury occur at home, on farm, industrial place, in public place? Aboard ship While at work? No
(d) Means of injury? fell into water from pier while walking

23. Signature Howard A. Kelly M.D.
Medical Examiner.

Date signed 8-23-46

VS 151

HEALTH DEPARTMENT—CITY OF BALTIMORE

G43202 G43202

CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Lafayette St. Ward)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Arthur Redding 17

If U. S. Veteran specify WAR

(a) Residence: No. 605 Lafayette Ave. Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Redding

6. DATE OF BIRTH (month, day, year) 9-14-1894

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
51	11	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) High Point N. C.

FATHER

13. NAME George Redding

14. BIRTHPLACE (city or town) (State or country) N. C.

MOTHER

15. MAIDEN NAME Sarah ?

16. BIRTHPLACE (city or town) (State or country) N. C.

17. INFORMANT Sarah Redding

(Address) 605 N. Lafayette ave

18. BURIAL, CREMATION, OR REMOVAL

Place W. Auburn Cem. Date 8-25 1946

19. UNDERTAKER William A Fuchs

(Address) 916 Pennsylvania ave

20. FILED AUG 26 1946 19 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 8/26/1946

22. I HEREBY CERTIFY, That I attended deceased from 8/16/1946 19 to 8/26/1946 19

I last saw h alive on 8/22/1946. Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	
Contributory	

Other contributory causes of importance

Arteriosclerosis

Was an autopsy?

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

How, specify

(Signed) H. Ley Ellers M. D.

(Address) 921 Madison ave

X

G43203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46B

G43203 Registered No.

Please answer all questions as completely as information should be carefully supplied. The accuracy of information is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Linden Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Linden ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S Stewart

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-22-1889

8. AGE: Years	Months	Days	If less than one day
57	6	3	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Jerry Stewart
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Stewart
15. Birthplace Va

16 (a) Informant Grace Hayes
(b) Address 1010 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pemba ave

19 (a) AUG 26 1946 Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1946, at 10.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1946, to Aug 25 1946, and that I last saw h— alive on Aug 24 1946

Immediate cause of death: Cancer of Stomach — Duration 1 yr

Due to

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Pettigrew M. D.
Address 417 Hamilton Ave Date signed Aug 26 '46

VS 150

G43204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

X G43204 Registered No.

Please write plainly. Information should be carefully supplied. The please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Streets.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore ~~(yrs., mos., or days)~~ 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore ; Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena & Altamont Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Germania S. Reus

3 (b) If veteran, name war none

3 (c) Social Security Account No. 217-05-9902

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Florida S. Reus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1874

8. AGE: Years	Months	Days	If less than one day
72	4	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER	12. Name John F. Reus
	13. Birthplace Germany
MOTHER	14. Maiden Name Louisa Kroeger
	15. Birthplace Germany

16 (a) Informant Hospital Records.
(b) Address 33rd. & Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Signature of registrar) (b) Registrar

AUG 26 1946

VS 15B

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1946, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1946 to Aug. 26, 1946, and that I last saw h[illegible] alive on Aug. 26, 1946.

Immediate cause of death	Duration
~~Respiratory failure~~ Cerebrovascular accident	7 days.
Due to ~~Cerebral failure~~	
Due to ~~Hypertensive cardiac~~ Cardiac failure	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address Union Memorial Hosp. Date signed 8-26-46

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

043205 / 30 D

Registered No. 043205

043205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2769 Tivoli Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2769 Tivoly Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angelo Dignazio

3 (b) If veteran, name war	3 (c) Social Security Account No.	
none	218-10-2847	
4. Sex	**5. Color or race**	**6 (a) Single, married, widowed, or divorced.**
Male	White	Married

6 (b) Name of husband or wife Rachele Dignazio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1st 1882

8. AGE: Years	Months	Days	If less than one day
64		24	hr. min.

9. Birthplace Teramo Abruzzi Italy (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Giovanni Dignazio
13. Birthplace Italy

MOTHER
14. Maiden Name Giacinta ?
15. Birthplace Italy

16 (a) Informant Rachele Dignazio (Wife)
(b) Address 2769 Tivoly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) AUG 26 1946 Huntington Williams, M.D. Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1943 to 8/25 1946 and that I last saw h[illegible] alive on 8/18 1946.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Luetic Cardio-Vascular Disease	7 ?
Due to	
Other Conditions Aneurism of Aorta	2

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jesse S. Blum M.D.
Address 1206 E. Preston Date signed 8/26/46

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The necessary supplies are furnished free by the Department of Health. Undertakers: please write the causes of death clearly and legibly.

G43206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

G43206 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 W Crow Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 12 1898

8. AGE: Years 48 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Hand man for Self

11. Industry or business

FATHER 12. Name James Oliver

13. Birthplace Va

MOTHER 14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Jessie Wallace

(b) Address 531 W Crow Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 1946 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn

Location Baltimore City

18 (a) Funeral director Joseph A. Tyler

(b) Address 661 W Baltimore Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1946 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16/46 1946 to 8/25 1946.
and that I last saw h[illegible] alive on 8/25 1946

Immediate cause of death

Cardio-vascular failure

Due to Syphilitic Aortitis & dilatation

Due to Syphilis C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Caseous TBC Lesions the both lungs

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph A. Tyler

Address Bricks. Hosp. Date signed 8/26

VS 150 AUG 26 1946 Huntington, W.Va.

Physician's age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G43207 X G43207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No.

Please answer all questions as completely as information known to you will permit. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Just Came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Pocomoke
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Dryden

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1875

8. AGE: Years	Months	Days	If less than one day
70	11	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name James Dryden
13. Birthplace Maryland

MOTHER
14. Maiden Name Mollie Welburn
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28-46 (month) (day) (year)
(c) Cemetery or crematory Pocomoke Cemetery
Location Pocomoke City, Md
18 (a) Funeral director H. Harvey Broadaway
(b) Address Pocomoke City, Md
19 (a) (Date rec'd by registrar) (b) Huntington Williams

AUG 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1946, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1946 to Aug 26 1946, and that I last saw h[illegible] alive on Aug 26 1946.

Immediate cause of death Respiratory Failure — Duration 3 hours

Due to Arteriosclerotic Cardio-Vascular Disease — ? yrs.

Due to

Other Conditions Uremia after Prostatectomy — 2 mos.
(Include pregnancy within 3 months of death)

Date of operation June 11, 1946

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Gentry M. D.
Address Mercy Hosp. Date signed 8-26-46

G43208 — BALTIMORE CITY HEALTH DEPARTMENT — G43208

CERTIFICATE OF DEATH

83A

Registered No.

Please write the causes of death clearly and legibly. Physicians: please be especially important. Physicians: please be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lexington Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Dorchester Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Simpson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-7296

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Benjamin Simpson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1909

8. AGE: Years	Months	Days	If less than one day
37	1	11	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Insurance

FATHER
12. Name John H. Laumann
13. Birthplace Ellicott City, Balto. Co. Md.

MOTHER
14. Maiden Name Mary Carter Laumann
15. Birthplace Howard Co., Md.

16 (a) Informant Henry Laumann
(b) Address 904 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1946 (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Ellicott City, Maryland.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Maryland

26 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1946, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1946 to Aug 25 1946, and that I last saw h[er] alive on Aug 25 1946

Immediate cause of death Subarachnoid Hemmorage — Duration 11 days

Due to Hypertension — Duration approx. 2 hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A Gentry M.D.
Address Mercy Hosp Date signed Aug 27 1946

VS 150

G43209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G43209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Underwood Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. Englar

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Mar

6 (b) Name of husband or wife: Myrtle Englar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1891

8. AGE: Years 55 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Md (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wilbom Englar

13. Birthplace

MOTHER 14. Maiden Name Sarah Jane

15. Birthplace

16 (a) Informant Mrs Evelyn Rickshur

(b) Address 410 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wilbom & Son

(b) Address 1219 Park Ave

19 (a) 8-1946 (Date received by local registrar) (b) Errington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1946, at 12 44 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1945 to 8/24 1946, and that I last saw him alive on 8/24 1946

Immediate cause of death: Arteriosclerotic heart disease — Duration: 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Edward Leach

Address 14 E. Eager St Date signed 8/26/46 M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

G43210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48B

G43210 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 346 W 29th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 346 W 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louisa H Beach

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Robert L Beach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1876

8. AGE: Years 70 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles B Johnson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lyson Clayton
15. Birthplace Baltimore Md

16 (a) Informant Lillian E Le Gozen
(b) Address 346 W 29th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkwood Md

18 (a) Funeral director Wilhelm & Son Inc
(b) Address 124 N Howard St

19 (a) 1946 Aug 26 Clayton Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1946, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1946 to Aug 25 1946 and that I last saw h[illegible] alive on Aug. 24 1946.

Immediate cause of death Cardio-Renal
a Day Failure

Due to Carcinoma uterus & bowel with metastasis (Cerebral)?

Due to

Other Conditions Arteriosclerosis Generalized
(Include pregnancy within 3 months of death)

Date of operation Past one May 10, 1946

Major findings of operation: Resection of colostomy

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4-E-32 1St Balto 17 Date signed 8-26-46

VS 150

G43211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

X G43211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. + Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Delta.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miriam Smith.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. Andy R. Smith
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March 29, 1880

8. AGE: Years	Months	Days	If less than one day
66	4	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas I. Norris (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Miller (D)
15. Birthplace

16 (a) Informant Hospital Records
(b) Address 33rd + Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Nebo
Location Delta Pa

18 (a) Funeral director Hubert P. Hankins
(b) Address Delta, Pa.

AUG 26 1946
(Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1946, at 10 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1946 to Aug. 26 1946, and that I last saw her alive on Aug 26 1946.

Immediate cause of death Respiratory failure — Duration

Due to Acidosis

Due to Diabetes mellitus

Other Conditions Fracture of left femur + Hemorrhage of Urinary tract
(Include pregnancy within 3 months of death)

Date of operation Aug. 17 1946

Major findings of operation: Comminuted intertrochanteric fracture, left femur

of autopsy: Aug 26 1946

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-6-46 at — M
(c) Where did injury occur? Delta, Pa.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Stepped over a suitcase

23. Signature A. L. Sturke, M.D. and Pee
Address Union Memorial Hospital Date signed 8/26/46
(over) Thomas J. Mullin, M.D.

VS 150

(Please print or write in ink. Every item should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.)

G43212 G43212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please report all information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Chesapeake St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Lally

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/05

8. AGE: Years	Months	Days	If less than one day
41 40	11	27	hr. min.

9. Birthplace Nebraska (Town, county, and state)
10. Usual Occupation Con Painter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mercy Hospital Records
(b) Address Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Rd. Balto.

18 (a) Funeral director H. W. Megarrow
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 26 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1946, at 2 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death: Respiratory failure — Duration

Due to Bronchogenic Ca

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David M. Lilly Jr. M.D.
Address Mercy Hospital signed 8/27/46

G43213 BALTIMORE CITY HEALTH DEPARTMENT G43213

CERTIFICATE OF DEATH 51C

Registered No.

Please write the information asked for below carefully and legibly. The accuracy of the information should be carefully supplied. The writing of the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Navarre (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Gleitsman, Raymond William

3 (b) If veteran, name war

3 (c) Social Security Account No. 296-16-4987

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1924

8. AGE: Years	Months	Days	If less than one day
22	1	15	hr. min.

9. Birthplace Navarre, Ohio (Town, county, and state)
10. Usual Occupation Fireman & watertender
11. Industry or business Seafarer

FATHER
12. Name Raymond Gleitsman
13. Birthplace Beach City, Ohio

MOTHER
14. Maiden Name Mable Gorius
15. Birthplace Navarre, Ohio

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Navarre Cem.
Location Navarre, Ohio

18 (a) Funeral director Oder Funeral Novelline
(b) Address 4644 York Road.

19 (a) (Signature of registrar) Huntington Williams M.D.
(b) AUG 26 1946 (Date received)
VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1946 4:40P M

21. I certify that death occurred on the date above stated: that I attended deceased from Aug. 16 1946 to Aug. 25 1946 and that I last saw him alive on Aug. 25 1946.

Immediate cause of death Carcinoma testicle with abdominal and pulmonary metastasis. — Duration 10 MOS.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 8/26/46

X

JL - 95353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G43214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr - 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 W. Hoffman St -1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Ann Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1879

8. AGE: Years 67 Months 3 Days 29 If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Miles
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Kelly
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Aug 30/946

(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director A. Hasted Sons
(b) Address 95 Washington Blvd

Date received by Registrar AUG 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1946, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1945 to Aug. 24 1946 and that I last saw h er alive on Aug. 24 1946

Immediate cause of death Pulmonary embolism — Duration 2 days

Due to Rheumatic Heart Disease — Duration 3 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Rowell Hoffman M. D.
Address Baltimore City Hospital Date signed 28 Aug 46

VS 150

Type or write with pen and ink. Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G43215 BALTIMORE CITY HEALTH DEPARTMENT G43215
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Eltinge St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Color or race Black

5. Color or race Black

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 03.

8. AGE: Years 43 Months Days If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Labarer

FATHER
12. Name Paymore Jenkins
13. Birthplace Va.

MOTHER
14. Maiden Name Bessie Brooke
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof Dec. 7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lovely Hope Cem
Location Frederick Road - Virginia

18 (a) Funeral director Wm. Francis A. Dunaway
(b) Address 5148 Reisterstown Rd.

19 (a) AUG 26 1946 (b) Registrar
(Date received by registrar)
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24 1946 at 8 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1946 to 8-24 1946 and that I last saw h[illegible] alive on 8-24 1946.

Immediate cause of death PNEUMONIA — Duration 2 weeks

Due to ? Tuberculosis — 2 weeks

Due to

Other Conditions Uremia — 1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas H. Leavell M.D.
Address Johns Hopkins Hosp Date signed 24 Aug

VS 150

Please write plainly. Important. Physicians: please write the causes of death clearly and legibly. The

G43216 D.C. Y-04557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 159

G43216 Registered No.

Please write the causes of death clearly and legibly. The accuracy of the answers to questions is necessary and important. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 521 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1946

8. AGE: Years	Months	Days	If less than one day
			10 hr. 25 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Willie Taylor
13. Birthplace Littleton, Md.

MOTHER
14. Maiden Name Emma Aleton
15. Birthplace Littleton, Md

16 (a) Informant Emma Taylor
(b) Address 521 N Barrie St, Balto, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 23 1946 Commissioner of Health

18 (a) Funeral director
(b) Address

AUG 27 1946 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1946, at 10 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16-1946 to 8-16-1946, and that I last saw h[illegible] alive on 8-16-1946.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George L. Lemon M. D.
Address Univ. Hosp. Date signed 8/26/46

G43217 — BALTIMORE CITY HEALTH DEPARTMENT — G43217

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 McCulloh
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1627 McCulloh
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mariah L. Oliver

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John F. Oliver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Balto, (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Benjamin Young
13. Birthplace Md

MOTHER
14. Maiden Name Annetta —
15. Birthplace Md

16 (a) Informant John F. Oliver
(b) Address 1627 McCulloh

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 1142 W Fayette St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

AUG 27 1946

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946 at 6.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased July 28 1946 Aug. 26 1946, and that I last saw her alive on Aug. 26 1946.

Immediate cause of death

Cerebral Embolism

Due to Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 Months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lindsay Skelton, M.D.
Address 908 E. Lexington St Date signed 8/26/46

Correct age is especially important. Physicians: please write the cause of death clearly and legibly. Information should be carefully supplied. The

G43218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83B

X G43218
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Hazelton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 146 N. Wyoming St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Barcasky, Stanley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marjorie Krapf Barcasky
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1901

8. AGE: Years 44 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace Hazelton, Pa.
(Town, county, and state)

10. Usual Occupation Pin ball machine operator
11. Industry or business

MOTHER / FATHER
12. Name Steve Barcasky
13. Birthplace Poland

14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/27/46 (month) (day) (year)
(c) Cemetery or crematory Hazelton Park
Location

18 (a) Funeral director Wm. B. Faulkner
(b) Address 2007 Eastern Ave

19 (a) Aug 27 1946 (Date received by registrar) (b) M.R.
Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946, to Aug. 27 1946, and that I last saw him alive on Aug. 27 1946.

Immediate cause of death Hypertensive vascular disease — Duration 7 yrs
(2) Cerebral thrombosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 8/27/46 M. D.

VS 150

X

G43219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43219 Registered No.

131A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Dor
(b) Street address 707 N. Duncan St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Korecky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER
12. Name Frank Korecky
13. Birthplace Bohemia

MOTHER
14. Maiden Name Sophia Krefci
15. Birthplace Bohemia

16 (a) Informant Anna Korecky
(b) Address 707 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Frank Lynch & Son
(b) Address 906 N. Chester St.

19 (a) AUG 27 1946 (b) (Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1946, at 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pribnick M.D.
Medical Examiner.
Date signed 8/26/46

G43220 131 A G43220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

The accuracy and completeness of information should be carefully supplied. The please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Bamish

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M.

6 (b) Name of husband or wife James Bamish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903 August 25,

8. AGE: Years	Months	Days	If less than one day
43	11	29	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Bourne.
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Maude Hutchins
15. Birthplace Calvert Co. Md.

16 (a) Informant Beatrice Bamish
(b) Address 612 S. Fremont

17 (a) Burial (b) Date thereof 8-28-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) AUG 27 1946 (b)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1946, at 1:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1946, to 8/24 1946 and that I last saw h[illegible] alive on 8/24 1946.

Immediate cause of death Uremia — Duration

Due to Hypertension

Due to Malignant Hypertension

Other Conditions Hypertrophied dilated Heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Arteriosclerosis - Grade 4

PHYSICIAN
Underline the cause to which should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Sicks M. D.
Address University Hospital Date signed 8/27/46

Huntington Williams, M.D.

G13221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G13221 Registered No.

Please write clearly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Answer all questions if possible; if not applicable, write "none" or "not applicable" (except that "unknown" is not acceptable as an answer to date of death). Please write in ink. Do not abbreviate. Be sure that the personal particulars and statistical information should be carefully supplied. The space for exact hour of death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 N. Stockton St.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 N. Stockton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Duckett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Col	Widowed

6 (b) Name of husband or wife Samuel Duckett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1881

8. AGE: Years	Months	Days	If less than one day
65	3	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hawkins
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace Maryland

16 (a) Informant Leola Thomas
(b) Address 1319 N. Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/46 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Jos. D. Kelson
(b) Address 1303 Presstman St

19 (a) AUG 27 1946 (Date filed by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24, 1946. at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21, 1946. to Aug 24, 1946 and that I last saw h[illegible] alive on Aug 23, 1946.

Immediate cause of death	Duration
Broncho-Pneumonia	1 wk.
Due to	
Due to	
Other Conditions Myocarditis	10 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature MacDonald Bando M. D.
Address 2445 D. Hill Ave. Date signed 8-27-46

VS 150

X

G43222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

X G43222 Registered No.

Type or use indelible ink. Information should be carefully supplied. The cause of death must be certified by a physician. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 East Hill Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Rolling Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA M. KLEMM

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George W. Klemmm
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 15 Jan. 1890

8. AGE: Years	Months	Days	If less than one day
56	7	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Henry Bockmann
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine M. Scheunn
15. Birthplace Maryland

16 (a) Informant Mr. George W. Klemm
(b) Address 105 S. Rolling Road

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 28 Aug. 46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 August 1946 at 11:15 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1, 1946 to Aug 25, 1946 and that I last saw h er alive on Aug 22, 1946.

Immediate cause of death
Due to
Due to
Other Conditions Varicose vein
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury H.P. Friedman M.D.
23. Signature
Address 1319 LIGHT STREET Date signed 8/26/46

VR AUG. Huntington Williams M.D. Registrar

Dr. H.P.Friedman X

G43223

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122A

G43223 Registered No.

Please answer all questions as completely as information should be carefully supplied. The space is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner of Redmond + Green Sts.
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME.** Lowman, Lillian (LILLIAN E. LOWMAN)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Gilbert Lowry
13. Birthplace Md

MOTHER 14. Maiden Name Harriet Snyder
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date then Aug 29-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Roff C + B.M. Walter
(b) Address Pratt + Charles Sts

19 (a) Filed Aug 27 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1946, at 7 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from August 6 1946, to Aug. 26 1946, and that I last saw he alive on Aug. 26 1946.

Immediate cause of death Shock — Duration

Due to Intestinal Obstruction

Due to Evisceration

Other Conditions Surgery, Cardiac Enlargement
(Include pregnancy within 3 months of death)

Date of operation Aug. 17, 1946

Major findings of operation: Removal Hernia with Eviscerated Bowell

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address University Hosp. Baltimore Md. M. D.
Date signed 8-26-46

VS 150

G43224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G43224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 S. Eden St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 S. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABE SANDLER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tracer
11. Industry or business

FATHER 12. Name Moses
13. Birthplace Russia

MOTHER 14. Maiden Name Mersel
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Park Rd + Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) (Signature of registrar) (b) Huntington Woods Baltimore

AUG 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 | 26 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 | 1 1946 to 8 | 26 1946, and that I last saw h[illegible] alive on 8 | 26 1946.

Immediate cause of death Acute Cardiac dilatation — Duration

Due to

Due to Chronic coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. C. Feldman M. D.
Address 144 E Balto Date signed 8/27/46

Please answer all questions as specially important. Physicians: please write the causes of death clearly and legibly.

643225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 643225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2426 E. Fayette
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 E. Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Gustomolahy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ~~Peter~~ Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Reddy
15. Birthplace Russia

16 (a) Informant Mr. Howard Lancaster
(b) Address 2426 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Park Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) Huntington Williams, M.D. (Date received by registrar) Registrar

UG 2

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1946 to 8/26 1946 and that I last saw h[illegible] alive on 8/26 1946

Immediate cause of death	Duration
Coronary Occlusion	10 Min.
Due to Chronic Myocarditis	3 yrs.
Due to Hypertension	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Levin, M.D.
Address 607 N. Broadway Signed 8/27/46

VS 150

For S.C.J. Fabrowski, by Howard J. Levin, M.D. /X

G43226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G43226
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the information requested. The accuracy of the information is extremely important. Please write carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 E. BIDDLE ST
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 E. BIDDLE ST
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SUSAN AGNES LORDEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife DANIEL A. LORDEN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) NOV. 4 - 1865

8. AGE: Years	Months	Days	If less than one day
80	9	22	hr. min.

9. Birthplace BALTIMORE CO. MD.
(Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name JAMES CONSIDINE
13. Birthplace IRELAND

MOTHER
14. Maiden Name SUSAN MAC DONALD
15. Birthplace IRELAND

16 (a) Informant MISS SUSAN LORDEN
(b) Address 608 E. BIDDLE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/29/46 (month) (day) (year)
(c) Cemetery or crematory ST. MARY'S
Location GOVANS

18 (a) Funeral director Chas. J. Cramer Son
(b) Address 118 N. [illegible]

19 (a) [illegible] 1946 (b) [illegible]
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1946 to Aug 26 1946 and that I last saw h[illegible] alive on Aug 26 1946

Immediate cause of death Bronchial Pneumonia — 3 days
Due to Cerebral Hemorrhage — 2 days
Due to —
Other conditions Age & Arterio Sclerosis
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide NO
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature R. L. Keyser M.D.
Address 1 Wentworth Apts. Date signed 8-29-46

WENTWORTH ARMS APTS.

G43227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

G43227
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 Peach St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Saddler

3 (b) If veteran, name war

3 (c) Social Security Account No. 211-01-1310

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name John saddler
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ora Johnson
15. Birthplace georgia

16. (a) Informant Sarah Russell
(b) Address 722 Ricketts Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Walter B Jones
(b) Address 139 W Hamburg St

19 (a) AUG 27 1946 (Date received by Registrar) (b) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1946 at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Anemia Pulmonary Tuberculosis

Due to

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8-22-46

643228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146P

Registered No. 643228

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5213- Etherbert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Norman Forney

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-2577

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5 1905

8. AGE: Years	Months	Days	If less than one day
40	9	21	hr. min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name John Thomas Forney
13. Birthplace Carroll County, Md.

MOTHER
14. Maiden Name Annie Harmon
15. Birthplace Carroll County, Md.

16 (a) Informant Annie Harmon
(b) Address Carroll County, Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Aug. 29 46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Harry A. Armacost
(b) Address 4204 Ridgewood, Balto.

19 (a) AUG 27 1946 (Date received by Registrar) **(b)** Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1946, at 4.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage

Due to

Other Conditions Hematoma of scalp, lacerations, contusions & bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 8-25-46 at 8:45 P.M.
(b) Where did injury occur? Found: Belvedere Ave., 50' East of Reisterstown Road (south side)
(c) Did injury occur at home, on farm, industrial place, in public place? Public **While at work?** No
(d) Means of injury Probably fell to ground striking head

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 8-27-46

Please write the causes of death clearly and legibly. The information should be carefully supplied. The Registrar will specially importune Physicians: please

G43229 Bkg. 55336 BALTIMORE CITY HEALTH DEPARTMENT G43229
CERTIFICATE OF DEATH 160 A Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution:
So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Patapsco St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Her~~ Baby Girl Baird

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-26-46

8. AGE: Years | Months | Days | If less than one day 1/2 hr. min.

9. Birthplace So Baltimore Hosp
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Burnet Baird
13. Birthplace Ohio

MOTHER
14. Maiden Name LaVerne Winters
15. Birthplace Potts- Md

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 8-31-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.G.Co. Md

18 (a) Funeral director Flynn & Flannery
(b) Address 1412 Light St

19 AUG 27 1946 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1946 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1946 to 8/26 1946, and that I last saw her alive on 8/26 1946.

Immediate cause of death R.D.S.
Railure

Due to INTra Cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: INTra Cranial Hemorrhage

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burnet Shipley MD
Address 1211 Light St. Date signed 8/27/46

VS 150

G43230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G43230 Registered No.

Please answer questions fully. Information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 E. Lexington st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 E. Lexington st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	M

6 (b) Name of husband or wife Emma King
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Emma H King
(b) Address 1112 E Lexington st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Mrs Dola Bailey
(b) Address 1421 E. Jefferson st

19 (a) (Date rec'd by registrar) (b) Clinton Williams, Registrar

AUG 27 1946 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946, at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1946 to Aug 24 1946 and that I last saw h.e alive on Aug 24 1946

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to Arterio-sclerosis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marrs B. Dorsey M. D.
Address 118 Biscayne Date signed 8/26/46

X

G43231

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186A

G43231 Registered No.

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 N Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Carew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Rose (nee Burgess)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, ~~1874~~ 1881

8. AGE: Years	Months	Days	If less than one day
65 ~~74~~	7	21	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City

FATHER
12. Name Germia Carew
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigid Keating
15. Birthplace Ireland

16 (a) Informant Bessie Scanell
(b) Address 2602 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ New Cathedral
Location 4300 Old Frederick Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) (Date received by registrar) (b) Huntington Wilkinson (Registrar)

AUG 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Aug 1946, at 1:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of 2nd & 4th Cervical vertebrae

Due to

Other Conditions Arteriosclerotic Cardio-vascular Renal disease.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 8/25/46 at 11 P. M.
(b) Where did injury occur? 1417 N. Washington St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall down steps

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8/26/46

vs 1946

G43232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G43232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hosp. 1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 S. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK G. G. SCHELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-3500

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Orma Schell

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1904.

8. AGE: Years	Months	Days	If less than one day
42	6	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Manager.

11. Industry or business Schell Transfer Co.

FATHER
12. Name Valentine J. Schell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Rodenberg.
15. Birthplace Baltimore, Md.

16 (a) Informant Orma Schell (Wife)
(b) Address 339 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-46. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Gorsuch Mill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) AUG 27 1946 (Date rec'd by registrar) Washington Wilkinson, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26/46 19 46, at 1:00 p.m. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis M.D.
Medical Examiner.
Date signed 8/26/46

G43233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G43233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 860 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Boarden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10 1877

8. AGE: Years	Months	Days	If less than one day
69	10	18	hr. min.

9. Birthplace Eastern Maryland (Town, county, and state)

10. Usual Occupation Work for Self

11. Industry or business

FATHER
12. Name James A. Booden
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Haywood
15. Birthplace Maryland

16 (a) Informant Abert Smyth
(b) Address 740 Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Leonard Whaley
(b) Address 200 McCulloh St

19 (a) AUG 29 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1946 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. L. Sudbrink Jr. M.D. Medical Examiner.
Date signed 8/29/46

VS 181

G43234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G43234 Registered No.

The information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 334 S. Pulaski St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gustave Kuhn (Kuehn)

3 (b) If veteran, name war	3 (c) Social Security Account No.
Unknown	Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1893

8. AGE: Years	Months	Days	If less than one day
53	0	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Material Distributor
11. Industry or business B. & O. R. R.

FATHER
12. Name Gustave Kuhn
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine Bunker
15. Birthplace Germany

16 (a) Informant Emma Hedrick
(b) Address 334 S. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 46 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Woodlawn, Balto. city

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (Date received by registrar) AUG 28 1946 Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1946, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 August 1946, to 26 August 1946, and that I last saw h/ alive on 26 August 1946.

Immediate cause of death	Duration
Terminal Bronchopneumonia	5 days
Due to Final report on exam. of brain to be delayed 10 days for	
Due to proper fixation.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Hedrick M.D.
Address Franklin Sq Hosp Date signed 8/31/46

G43235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 C X

G43235 Registered No.

Please write the causes of death clearly and legibly. The information must be carefully supplied. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Roanoke
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Willard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Thigpen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elaine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-19-92

8. AGE: Years	Months	Days	If less than one day
53 54	10	8	hr. min.

9. Birthplace Mississippi (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Linston Thigpen

13. Birthplace Ala

MOTHER 14. Maiden Name Elizabeth Byers

15. Birthplace Miss

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address Records.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Newport News, Va

18 (a) Funeral director W. J. Tuchman & Son

(b) Address North & Emma Aves

19 (a) AUG 28 1946 (Date rec'd by registrar) (b) Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946 at 6 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1946, to Aug 27 1946, and that I last saw he alive on Aug. 27 1946.

Immediate cause of death: Bronchiogenic carcinoma with metastases to mediastinum and liver

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. M. Knight, Jr., M. D.

Address Date signed 8/27/46

VS 150

G43236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576 E

X G43236 Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. Physicians: please write your [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Queens Village LI
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215-34 Hillside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sheldon Davidson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-8-29

8. AGE: Years	Months	Days	If less than one day
17	1	19	hr. min.

9. Birthplace NY (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thos Davidson
13. Birthplace Rumania

MOTHER
14. Maiden Name Sadie Garner
15. Birthplace NY

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Record

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt Arrarat Cem
Location Farmingdale R.I.

18 (a) Funeral director Jack Lewis Inc
(b) Address 4096 Balto St

19 (a) AUG 28 1946 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-20 1946 to Aug-27 1946 and that I last saw h[illegible] alive on Aug. 27 1946.

Immediate cause of death
Hemothorax and cerebral vas. thrombosis — Duration 2 d.
Due to Operation for.
Due to Cong. Heart dis. & Pulmonary stenosis — Life
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8-27-46
Major findings of operation Pulmonary Stenosis.
of autopsy Hemothorax - "

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. B. Morrow
Address JHH
Date signed 8-27-46 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

043237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 043237

Type or use ink. Information should be carefully supplied. The space for age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Park Heights ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvia Cohen Fleinberg

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Late David
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860 or 71

8. AGE: Years	Months	Days	If less than one day
86 (75)	-	—	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Daniel Richter
13. Birthplace Russia

MOTHER
14. Maiden Name Esthere —
15. Birthplace Russia

16 (a) Informant Mr Mayer Cohen
(b) Address 2609 Park Heights ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/46 ; (month) (day) (year)
(c) Cemetery or crematory Ritz Chaim Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 AUG 28 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946, at 7:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/40 19__ to 8/26 1946 and that I last saw h[illegible] alive on 8/25 1946

Immediate cause of death: Cancer of
Due to Metastasis of
Due to Stomache
Other Conditions Duodenal Ulcer

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Chidecker M. D.
Address 2775 Linden Date signed 8/26/46

VS 150

G43238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1936

Registered No. G43238

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 Brooks Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Brooks Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph S. Baum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and State)

10. Usual Occupation Tailor Shop

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mildred Baum
(b) Address 811 Brooks Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-46 (month) (day) (year)
(c) Cemetery or crematory Shaar Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 4396 Balto St.

19 (a) AUG 28 1946 Registrar Washington Williams, M.D.

MEDICAL CERTIFICATE

20. DATE OF DEATH 8-26- 1946 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1946 to 8/26 1946 and that I last saw h. alive on 8/26/46 1946

Immediate cause of death: Coronary Thrombosis — Duration 36 hr
Due to: Arteriosclerotic Hrt. Dis. — 5 mo
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature H. M. S. Stirling M. D.
Address 2426 Eutaw Place Date signed 8/27/46

VS 150

H. M. S. Stirling

G43239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/3/18

Registered No. G43239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 N. Gilmore (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Watson, Greenwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (Married), widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife Selma Watson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 - 1 - 1900

8. AGE: Years	Months	Days	If less than one day
45	7	26	hr. min.

9. Birthplace Windsor N.C. (town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Arthur Watson
13. Birthplace Windsor N.C.

MOTHER
14. Maiden Name Martha
15. Birthplace

16 (a) Informant Selma Watson
(b) Address Wife

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 AUG 28 1946 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1946, at 10-5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24- 1946 to 8-26 1946 and that I last saw him alive on 8-26 1946.

Immediate cause of death	Duration
Uremia	48 hrs
Due to Malignant Hypertension	10 yrs
Due to Chronic Glomerular Nephritis	12 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Chronic Glomerula Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Morley St Date signed 8-27-46

VS 150

G43240 B C# G 46416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 244

G43240
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 Aliceanna St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Sawyer.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-46

8. AGE: Years | Months 4.3 | Days 26 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Sawyer.
13. Birthplace N.C.

MOTHER 14. Maiden Name Betty Boyce
15. Birthplace Ky.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Tilly & Geiler Sons
(b) Address 403 S. Wolfe Street

AUG 28 1946 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946 at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1946 to Aug. 27 1946 and that I last saw h.er alive on Aug. 27 1946.

Immediate cause of death: Septicemia — Duration: 1 day

Due to: not known except

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: no definite findings given

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Demetrius D. Zaggis M. D.
Address Johns Hopkins Hospital Date signed 8/27/46

G13241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G13241

The entries on this certificate should be carefully supplied. The causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1642 E. Pratt Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 8 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Sybil Warner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 / 3/1902

8. AGE: Years 44 | Months 0 | Days 23 | If less than one day: hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name ? Johnson
13. Birthplace Alabama

MOTHER
14. Maiden Name Effie ?
15. Birthplace Alabama

16 (a) Informant Harold Warner, (hus)
(b) Address 1642 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 / 29/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Gailor, Inc.
(b) Address 403 S. Wolfe Street

19 (a) AUG 28 1946 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26th 1946, at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1946 to Aug 26 1946 and that I last saw h[illegible] alive on Aug. 25 1946

Immediate cause of death: Carcinoma of Uterus
Interval between onset and death
Due to Cardiac Insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2529 East [illegible] Date signed

VS 150

G13242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A ✓ Registered No. G13242

Please write the causes of death clearly and legibly. Physicians: please answer all questions especially important. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2318 Guilford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgiana Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	widowed

6 (b) Name of husband or wife Peter Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Howard County
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Laura Morrison Gould
(b) Address 2318 Guilford Ave

17 (a) Burial (b) Date thereof 8/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park.
Location Baltimore - Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson St.

19 (a) (Date received by local registrar) AUG 28 1946 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1946, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1946 to Aug 28 1946, and that I last saw h alive on Aug 28 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. J. Bayfield M. D.

Address 722 N Fulton Ave Date signed 8/29/46

VS 150

G13243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

Registered No. G13243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 S Vincent St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 S Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael H Halpin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1869

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Halpin
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Butler
15. Birthplace Ireland

16 (a) Informant Mrs Julia Milesky
(b) Address 216 S. Vincent St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/29/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J Govan & Son
(b) Address 1145 N Pollitt St

19 (a) AUG 28 1946 (Date rec'd by registrar) Washington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946, at 11 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 August 1946 to 26 August 1946, and that I last saw him alive on 26 Aug. 1946

Immediate cause of death	Duration
Acute Pulmonary Oedema	
Due to chronic myocarditis	
Due to	
Other Conditions Fracture Left Hip	13 Days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 19-4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-13-46 at A. M
(c) Where did injury occur? 216 S. Vincent St
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped & fell to floor

23. Signature Nathan Raemin
Address 206 S. Gilmor St Date signed M. D. 8-27-46

VS 150

Howard J. Meredith, M.D.

The information should be carefully supplied. The causes of death clearly and legibly. Physicians: please write the

FG 3244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G43244

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4018 Liberty Heights
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 4018 Liberty Heights (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Cohen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years 64 Months Days If less than one day hr. min.
9. Birthplace Russia (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Hilda
15. Birthplace Russia

16 (a) Informant Samuel Cohen
(b) Address 4018 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lauer Inc
(b) Address 1409 E Balto St

19. Filed AUG 28 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1946, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1946, to 8/27 1946, and that I last saw h[illegible] alive on 8/27 1946.

Immediate cause of death: Acute Cardiac Decompensation — Duration: 1 day
Due to: Coronary artery disease — 6 months
Due to: Diabetes Mellitus — 6 years
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2320 Eutaw Pl Date signed 8/28/46

VS 150

G43245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A

Registered No. G43245

Please answer all questions as completely as possible. Typewriter or print plainly in black ink. Where information should be carefully supplied. The space is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 Woodbine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES Worner ROSE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Madeline L. Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1917

8. AGE: Years	Months	Days	If less than one day
28	10	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Charles Lee Rose
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elsa Lauterbach
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Madeline L. Rose
(b) Address 3613 Woodbine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington (Date rec'd by registrar) (b) Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 19 46 to Aug 27 1946 and that I last saw h alive on Aug 27 19 46

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Hypertension — 6 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Hemorrhage.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard E. Blumenthal
Address W B & H Date signed 8/30/46

Howard J. Lundeen M.D.

VS 150

G43246 BC# 19765 ✓ G43246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170 C

Registered No.

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: East Baltimore Genera. Hospita. 154
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2334 N. Monroe Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Timothy John Renehan

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1940

8. AGE: Years	Months	Days	If less than one day
5	8	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William J. Renehan
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Thelma Klein
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Thelma Renehan
(b) Address 2334 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 8/28/1946 (b) Huntington Williams, M.D. Registrar
(Date filed by registrar)

VS 181

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Aug. 27, 1946, at 11.50 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Liver
Multiple fracture
Due to
Other Conditions Fractures, bruises,
head injuries.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15-C
(a) Date of injury 8-27-46 at 11.15 A. M.
(b) Where did injury occur? 2000 block Clifton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian -struck by auto

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-27-46

G43247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 A

G43247
Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Laurale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 W. Laurale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Harrison Mercer

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	W

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/1878

8. AGE: Years	Months	Days	If less than one day
67	8	26	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Mercer
13. Birthplace Md

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Hilda Hall
(b) Address 1307 W. Laurale St

17 (a) Burial (b) Date thereof 8/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pennsylvania Ave, Huntington Woodlawn, Md.

19 (a) 8/28/46 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1946 to Aug 26 1946 and that I last saw h[illegible] alive on Aug 26 1946.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H H Banfield
Address 722 N. Fulton Ave Date signed Aug 27/46
M. D.

VS 190

G43248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G43248

Please write the information should be carefully supplied. The causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Bennett St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Polly Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Edward Johnson,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876 - April 19

8. AGE: Years	Months	Days	If less than one day
70	4	7	hr. min.

9. Birthplace Amelia Co., Virginia
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Thomas Johnson.
13. Birthplace Amelia Co, Va.

MOTHER
14. Maiden Name Eliza Earls
15. Birthplace Amelia Co., Va.

16 (a) Informant Jennie White
(b) Address 904 Bennett Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Blackstone
Location Virginia

18 (a) Funeral director Mrs. R. Williams
(b) Address 322 N Schroeder St
19 (Delivered by) (Signature) Huntington Williams, M.D.

AUG 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26/46 15 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1946 to 8/26 1946 and that I last saw h[illegible] alive on 1946

Immediate cause of death
(a) R.F. Gobar
Due to Pneumonia
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert Crane M. D.
Address 1131 Harlem Ave Date signed 8/28/46

VS 150

G43249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 D

G43249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Marx Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Marx Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances L. Semski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~XXXX~~ Michael

6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) July 25th, 1880

8. AGE: Years 66 | Months 1 | Days 2 | If less than one day hr min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Agnes Weiland
(b) Address 4404 Marx Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 S. Ann st

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

AUG 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27th 1946 at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1946 to Aug 27 1946, and that I last saw h[illegible] alive on Aug 27 1946.

Immediate cause of death: Carcinoma - Bladder — Duration

Due to

Due to

Other Conditions: Unresected Incontinence
(Including pregnancy within 3 months of death)

Date of operation March 23, 1946

Major findings of operation: Tumor Central portion of bladder.

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Schwenck

Address 1373 S. Charles St. Date signed 8/29/46 M.D.

G43250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183 X

G43250 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State La. (b) County
(c) City or town New Orleans (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Jackson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Anthony Lester

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Beatrice Billit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-20-1919

8. AGE: Years	Months	Days	If less than one day
28	6	5	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business Merchant Marine

FATHER
12. Name Louis C. Lester
13. Birthplace Houma, La.

MOTHER
14. Maiden Name Eva B. Bergeron
15. Birthplace Houma La.

16 (a) Informant Lester Eagan Funeral Home
(b) Address New Orleans La

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/28/46 (month) (day) (year)
(c) Cemetery or crematory New Orleans
Location New Orleans La

18 (a) Funeral director Anthony Eagan Inc
(b) Address 1219 St Louis St

19 AUG 28 1946 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1946, at 2:50 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/24/46 at 2-3 P.M.
(b) Where did injury occur? Harbor - Foot of Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury? Fell into Balto. City Harbor

23. Signature Howard J. Werner M.D.
Medical Examiner.
Date signed 8-26-46

Huntington Williams, M.D.

G43251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G43251 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie J. Hogan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	5	hr. min.

9. Birthplace New Oxford, Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Joseph Miller
13. Birthplace Penna
14. Maiden Name Nancy Gamp
15. Birthplace Penna

16 (a) Informant Loretta Ann Hogan
(b) Address 15 North Monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director George L. Finley
(b) Address Fulton & Fayette

AUG 29 1946 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1946, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1945, to Aug 28 1946, and that I last saw her alive on Aug 28 1946.

Immediate cause of death Cardiovascular Collapse. - 4 days. — Duration

Due to Arteriosclerosis.

Due to

Other Conditions Senile Psychosis Simple deterioration.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond P. Hayes M. D.
Address 23 W. Preston St. Signed

643252 Over

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161A ✓ G43252 Registered No.

Typewriter or information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 24-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Cookesie St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lambert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-26-46

8. AGE: Years	Months	Days	If less than one day
			34 hr. 15 min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Lambert
13. Birthplace Md.

MOTHER
14. Maiden Name Lelia Starr
15. Birthplace W Va

16 (a) Informant Hospt. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-46 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto

18 (a) Funeral director George W. Farley
(b) Address Fayette & Fulton
(Date received by registrar) Huntington Williams M.D. (Registrar)

AUG 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1946 at 11:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1946 to 8-27 1946, and that I last saw him alive on 8-27 1946

Immediate cause of death Atelectasis due to Bronchial Obstruction — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J Knopf M.D.
Address Mercy Hosp (Signed)

G43253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G43253

Type or use ink. Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Oxford St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Frank Johnson

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1894

8. AGE: Years	Months	Days	If less than one day
51	8	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation plumber
11. Industry or business plumbing

FATHER
12. Name Howard Johnson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Baltimore, Maryland

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/46 (month) (day) (year)
(c) Cemetery ——— Balto. national
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 AUG 29 1946 (Date received by local registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946 at 10:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1946, to Aug. 25 1946, and that I last saw him alive on Aug. 25 1946.

	Duration
Immediate cause of death Pneumonia, lobar, left lower and right middle lobe.	1 to 2 weeks
Due to nephritis, acute.	1 to 2 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surg., Clinical Director
Address U. S. Marine Hosp. Balto Md. Date signed

VS 150

G43254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G43254 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Mosby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Bessie Graham
(b) Address 1029 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1946 (month, day, year)
(c) Cemetery or crematory Arb Park
Location

18 (a) Funeral director A Hartlead
(b) Address 9 N Eutaw St

AUG 29 1946 (a) (Date received by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1946, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1946 to 8/27 1946, and that I last saw h[illegible] alive on 8/27 1946.

Immediate cause of death: Carcinoma of Liver — Duration: 2

Due to

Due to

Other Conditions Jaundice

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. W. Pentlung M.D.
Address 416 N. Johns St Date signed 8/29/46

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G43255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

G43255 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 N Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 N Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H Bley

3 (b) If veteran, name war: —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1860

8. AGE: Years 85 | Months 8 | Days 13 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Shirt Maker

FATHER
12. Name John H. Bley.
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Annie L Bley
(b) Address 2109 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Anderson Md

18 (a) Funeral director Wilson & Lee
(b) Address 1-1704 Pennsylvania Ave

19 (a) Date received by registrar 1946 (b) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1946 at 8 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1946, to Aug 28 1946, and that I last saw him alive on Aug 10 1946

Immediate cause of death: Cerebral Embolism — Duration: 12 days ?
Due to: Carcinoma of Head? — 2
Due to: Pancreas.
Other Conditions: Chronic Nephritis — 3
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Daniel Robertson M. D.
Address 835 Forest Park Ave Date signed Aug 31 1946

VS 150

G43256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G43256
Registered No.

Please answer questions carefully and completely. Information should be carefully supplied. The physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula B. Liberto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband: Samuel T. Liberto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 11th 1885

8. AGE: Years: 61 | Months: 4 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Cecil Co. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Charles W. Pugh
13. Birthplace: Md.

MOTHER
14. Maiden Name: Rachel Woodrow
15. Birthplace: Md.

16 (a) Informant: Samuel T. Liberto
(b) Address: 1839 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/31/46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul Street

AUG 29 1946 (Date received by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1946, to Aug. 28 1946, and that I last saw h[illegible] alive on Aug. 28 1946.

Immediate cause of death: Heart failure — Duration: 2 wks.

Due to: Arteriosclerotic cardio-vascular disease — Duration: 2-3 yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Edw. H. Southwick M.D.
Address: Franklin Sq Hosp Date signed: 8/28/46

3257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G43257
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3041 Elliott st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Da A
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 Elliott st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Malczewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-7706

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Pensioner
11. Industry or business Social security

FATHER
12. Name Jacob Malczewski
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine
15. Birthplace Germany Segre

16 (a) Informant Mrs. Cecelia Malczewska
(b) Address 3041 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30 '46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Druid Hill Ave

18 (a) Funeral director Thomas J. Fialkowski INC
(b) Address 1800 N. Kenwood Ave

AUG 29 1946 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1946, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Meeks M.D.
Medical Examiner.
Date signed 8-26-46

VS 191

3258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G43258 Registered No.

Type or print in ink. This certificate should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 E. Madison Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 E. Madison Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH KOLARIK

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or ~~wife~~: Anthony Kolarik
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1890

8. AGE: Years 56 yrs. | Months 3 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Kysour
13. Birthplace Austria

MOTHER
14. Maiden Name Marie Supik
15. Birthplace Austria

16 (a) Informant Anthony Kolarik
(b) Address 2820 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4420 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

AUG 29 1946 (Date rec'd by registrar)

(d) Huntington Nolligner, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Aug 26 1946, and that I last saw her alive on Aug 26 1946.

Immediate cause of death: Coronary Thrombosis — Duration 8/26/46

Due to Chr. Myocarditis — 7/15/45

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rysavy M. D.
Address 801 W. Lexington Date signed 8/25/46

G43259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G43259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwards Green Hosp
(c) Hospital or institution: Univ of Md. 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 dy
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Lawrence Byrd.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Balto. Md. Va.
(Town, county and state)

10. Usual Occupation Woodchopper.
11. Industry or business

FATHER
12. Name Doctor Byrd
13. Birthplace Va

MOTHER
14. Maiden Name Mary Morgan
15. Birthplace Nottaway Co. Va

16 (a) Informant Lou Vonce Byrd
(b) Address 1010 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Chas. H. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1946 to 8/26 1946 and that I last saw him alive on 8/26 1946

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Senile pulmonary Tbc - Bilateral	
Due to Tuberculous Meningitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph L. Thacker
Address Univ. Hosp. Date signed 8/26/46

X

G13260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G13260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Moore Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1939

8. AGE: Years	Months	Days	If less than one day
6	10	15	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John a moore
13. Birthplace Va.

MOTHER
14. Maiden Name Lodie A. Brown
15. Birthplace 729 S Hanover

16 (a) Informant Mrs John a moore
(b) Address 729 S. Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd.

18 (a) Funeral director John J Denny Jr
(b) Address 718 Light St

19 (a) Filed AUG 29 1946 (b) Registrar Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946, at 10:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-27-46 at 10 A 24-4 M.
(b) Where did injury occur? Foot of William St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J Madden M.D.
Medical Examiner.
Date signed 8-27-46

G43261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

✓ G43261 Registered No.

Please write the causes of death clearly and legibly. Physicians: please ... information should be carefully supplied. ... is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Ridgewood Ave
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Ridgewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Frederick Arrings

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Arrings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1878

8. AGE: Years	Months	Days	If less than one day
67	8	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name William Henry Arrings
13. Birthplace Woodlawn Md

MOTHER
14. Maiden Name Lillian Hayes
15. Birthplace Baltimore Md.

16 (a) Informant Mary E. Arrings
(b) Address 4708 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry N. Annarel
(b) Address 4204 Ridgewood Ave

AUG 29 1946 (Date received by registrar) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1946 at 10.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to 8/28 1946; and that I last saw h alive on 8/28 1946.

Immediate cause of death
(a) Carcinoma of Stomach — Duration 1 yr
(b) Metal Degeneration — 1 yr
(c) Cerebral Hemorrhage — 2 hrs
Due to (d) Arteriosclerosis — 2 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry N. Annarel
Address 3802 Ironwood Rd Date signed 8/28/46

G43262

498950.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G43262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Whilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert F. Leach.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Grace Hitchens

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-5-73

8. AGE: Years	Months	Days	If less than one day
73	5	23	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business

FATHER 12. Name Robert Leach

13. Birthplace Md.

MOTHER 14. Maiden Name Priscilla Brosawell

15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 805 N. Calvert Street

AUG 29 1946 (Date received by Local Registrar) (b) Huntington Nitkin, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1946 at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1946 to Aug. 28 1946 and that I last saw h[illegible] alive on Aug. 28 1946.

Immediate cause of death: Uremia — Duration

Due to: Extensive CA Bladder, inoperable; BPH; Secondary anemia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 8-21-46

Major findings of operation: Inoperable CA Bladder

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. S. Donaldson M. D.

Address J. H. H. Date signed 8-28-46

G43263

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131A

G43263 Registered No.

Please answer clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East Street
(c) Hospital or institution: City Morgue 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4916 Pennington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Mechura

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 16, 1857

8. AGE: Years	Months	Days	If less than one day
89	5	11	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Mechura
13. Birthplace Austria

MOTHER
14. Maiden Name Anna ?
15. Birthplace Austria

16 (a) Informant Mary Mechura
(b) Address 4916 Pennington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel Co. Md

18 (a) Funeral director Frank Brocchus Son
(b) Address 900 E. Chase St

(c) AUG 29 1946 Huntington Woods Md
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946 at 1:30 p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Thomsen M.D.
Medical Examiner.
Date signed 8-27-46

G43264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G43264

Please write the causes of death clearly and legibly. Physicians: please see that this information should be carefully supplied. T

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 Rock Glen Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Rock Glen Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aurelie Warner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widow

6 (b) Name of husband or wife Late George Warner 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1874

8. AGE: Years	Months	Days	If less than one day
71	9	2	hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Bailey
13. Birthplace Canada

MOTHER 14. Maiden Name —
15. Birthplace Canada

16 (a) Informant Mrs. Henry O. Savard
(b) Address 501 Rock Glen Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Parkton, Md.

18 (a) Funeral director Harry A. Wintle
(b) Address 4401 Edmondson Ave

AUG 29 1946 (Date rec'd by registrar) (b) Huntington Wm. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946, at 12 10 P.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1946, to 8/27 1946 and that I last saw h alive on 8/25 1946

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Colloid-Vascular Disease & Hypertension	3 yrs.
Due to	
Other Conditions Cerebral Hemorrhage (Include pregnancy within 3 months of death)	3 days

Date of operation
Major findings of operation
of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3432 Druid Park Ave Date signed

G43265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G43265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light ST
(c) Hospital or institution:
So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Ridgely St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Hann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, Married, Widowed, or divorced Widowed

6 (b) Name of husband or wife Chas H. Hann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17-1898

8. AGE: Years 47 48 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Krug Kauffman

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown Foster

15. Birthplace Germany

16 (a) Informant Miss Elizabeth Hann

(b) Address 1525 Ridgely

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem

Location Baltimore

18 (a) Funeral director Maguire & Lyffel

(b) Address 1600 W. North ave.

Aug 29 1946 (b) Huntington, Md. (Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1946 at 11:12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 8-27 1946 and that I last saw h CR alive on 8-27 1946.

Immediate cause of death: acute Pulmonary Edema — Duration

Due to: acute Cardiac dilatation

Due to:

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature 4 Bonita Woods M.D.

Address 1211 Light St. Balto 30 Date signed 8-29-46

Howard L. Mendelsohn, M. D.

13268 Dr. Morris B. Schrieber
3500 Ellamont St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13A

G43266
Registered No.

The information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1338 Hollins St.
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1338 Hollins St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Gladys Brooks

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Robert Leon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov. 29, 1884
8. AGE: Years 61 | Months 8 | Days 28 | If less than one day: hr. min.
9. Birthplace: Indianna (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business:

FATHER: 12. Name: John Stockman
13. Birthplace: Indianna

MOTHER: 14. Maiden Name: Mary Nolan
15. Birthplace: Indianna

16 (a) Informant: Robert Leon Brooks
(b) Address: 1338 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 28/'46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Ellsworth Armacost
(b) Address: 3911 Liberty Heights Ave.

AUG 29 1946 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 26 1946 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1943 to 8-26 1946 and that I last saw h[illegible] alive on 8-25 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 months
Due to: hypertension — ?
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thomas B. Schrieber M. D.
Address: 4 Y S. Fulton Ky Date signed 8-28 '46

X

G43267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 31A

G43267 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 S Lehigh St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 S Lehigh St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Russo

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Devoiced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 8 1897

8. AGE: Years 49 | Months | Days 18 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Virginia

MOTHER 14. Maiden Name Minerva Allison
15. Birthplace Unknown

16 (a) Informant John C Rau
(b) Address 619 S Fulton Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 30-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave

18 (a) Funeral director John A Kogan
(b) Address 3000 E Baltimore St

19 AUG 29 1946 (b) Huntington Rothauser, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1944 to Aug 26 1946 and that I last saw h alive on Aug 25 1946.

Immediate cause of death Hypertension Cerebral Haemorrhage — Duration

2 years ago. Chronic

Due to Interstitial nephritis.

Terminal condition

Due to Coronary Occlusion.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C Bagham, M.D.
Address 3139 E. Baltimore St Date signed Aug 28 46

VS 150

G43268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G43268 Registered No.

Please answer questions below as accurately as possible. The information requested is important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give name)
(d) Street No. 425 N. Curley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martie F. Ward.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 1873

8. AGE: Years 73 | Months | Days 11 | If less than one day: hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Gardner
11. Industry or business Patterson Park

FATHER
12. Name Bernard Ward
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Grumley
15. Birthplace Balto. Md.

16 (a) Informant Mary B. Ward
(b) Address 425 N. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-46 (month) (day) (year)
(c) Cemetery or crematory Holy Red
Location Belair Rd

18 (a) Funeral director John A. McGann
(b) Address 3700 E. Baltimore St.

19 (a) AUG 29 1946 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Aug 1946 to 28 Aug 1946, and that I last saw him alive on 22 Aug 1946.

Immediate cause of death uremia — Duration 4-5 years

Due to chronic nephritis — 4-5 years

Due to chronic arteriosclerosis — 4-5 years

Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Randolph H. Spiegleman M. D.
Address 510 S. Desmond Ave, Date signed 29 Aug 46

VS 150

G43269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46D

X G43269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wash (b) County
(c) City or town Sprague (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola Swanmack (nee)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10 76

8. AGE: Years	Months	Days	If less than one day
70	6	18	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gellard Carper
13. Birthplace W. Va.

MOTHER
14. Maiden Name Martha Wimmer
15. Birthplace W. Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/46 (month) (day) (year)
(c) Cemetery or crematory
Location Sprague, Wash

18 (a) Funeral director John A. Mitchell & Son
(b) Address 1900 Eutaw Place
Huntington Williams, M.D. Registrar

19 (a) (b) AUG 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1946 at 3.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1946 to Aug 28 1946 and that I last saw her alive on Aug 28 46.

Immediate cause of death Circulatory Collapse — Duration

Due to Resection of carcinoma of the rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 28 August 46

Major findings of operation: Mass in rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard D. Cash M.D.
Address J.H.H. Date signed 28 Aug 46

VS 150

G43270

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30 F

G43270
Registered No.

Please answer questions or death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 755 W. Mulberry St
(c) Hospital or institution: H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 755 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-39

8. AGE: Years	Months	Days	If less than one day
7	10	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER 12. Name Herman Mason
13. Birthplace

MOTHER 14. Maiden Name Bernice Allen
15. Birthplace

16 (a) Informant Bernice Mason
(b) Address 755 W Mulberry St

17 (a) Burial (b) Date thereof 8/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bloomsbury Ave

19 AUG 29 1946
(Date rec'd by registrar)

Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital
Menings - vascular syphilis

Due to

Other Conditions Broncho-pneumonia, Malnutrition.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8/26/46

G43271 - 102185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

G43271
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1901

8. AGE: Years 45 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Albert Driscoll
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy G Wilson
(b) Address 1000 Boundary ave
(Date received by local registrar) AUG 29 1946 (b) Huntingtown Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1946, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1946 to Aug. 24 1946, and that I last saw h er alive on Aug. 24 1946.

Immediate cause of death: Respiratory Failure — Duration

Due to Pulmonary Infarction

Due to Rheumatic Heart disease Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Balt. City Hall Date signed 8-26-46

K

Important: Answer all questions as fully as possible. Physicians: please write the causes of death clearly and legibly.

G43272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47C

Registered No. G43272

The cause or causes of termination should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-10-16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George La Berry or George La Barre

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Grace (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1883

8. AGE: Years	Months	Days	If less than one day
62	8	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George L.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Schultz
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-30-46 (month) (day) (year)
(c) Cemetery or crematory W. Lawn Forest Lawn
Location
18 (a) Funeral director J. L. Cauley
(b) Address 50 S. Fort Ave.
19 (c) AUG 29 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28, 1946 at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1934 to Aug. 28 1946, and that I last saw him alive on Aug. 28 1946.

Immediate cause of death Respiratory failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

Bronchopneumonia Prostatectomy

of autopsy Bronchopneumonia Coronary Sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed Aug 29/46

VS 150

G43273

499685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 F

Registered No. G43273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 W. Cummings Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin E. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-46.

8. AGE: Years | Months: 1 | Days: 22. | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James A. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Rittle
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Rounds.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-46 (month) (day) (year)
(c) Cemetery or crematory Please Ret Cem
Location Towson Md Balto. Co.

18 (a) Funeral director Robert E. Jennings
(b) Address 150 Madison ave

AUG 29 1946 Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946 at 11.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1946 to Aug. 27 1946 and that I last saw h[illegible] alive on Aug. 27 1946

Immediate cause of death Syphilis congenital
resp failed — Duration 7wks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury
23. Signature Bertha Childs
Address Johns Hopkins Hosp Date signed 8-28-46

VS 150

Please write plainly and legibly.

G43274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G43274
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-5
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 E North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James G. Siverd (James Garnet Siverd

3 (b) If veteran, name war: World War # 1
3 (c) Social Security Account No. 173-16-2633

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy Turner Siverd
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1889

8. AGE: Years 57 | Months 7 | Days 13 | If less than one day: hr. min.

9. Birthplace: Chambersburg, Pa. (Town, county, and state)
10. Usual Occupation: Salesman - retired
11. Industry or business

FATHER
12. Name: James Siverd
13. Birthplace: Chambersburg, Pa.

MOTHER
14. Maiden Name: Grace Elder
15. Birthplace: Chambersburg, Pa.

16 (a) Informant: Mrs. Dorothy Siverd
(b) Address: 1639 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 29 1946 (Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 1946 at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Due to Hypertension Cardio-
& Vascular Disease
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William H. Hellman M.D.
Medical Examiner
Date signed 28 Aug 46

G43275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G43275
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 539 W. Conway St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Wilkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Cleveland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
45	SMT		hr. min.

9. Birthplace Enterprise, Ala.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Pink White
13. Birthplace Clintonville Ala

MOTHER
14. Maiden Name Mollie Hatton
15. Birthplace Enterprise, Ala.

16 (a) Informant Mamie Dickerson.
(b) Address 509 Bassé St.

17 (a) Burial (b) Date thereof Aug. 29, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary,
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 AUG 29 1946 (b) Huntington Williams
(Registered by Registrar) (Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1946 ~~P~~ M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s.t death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. S. Subin M.D.
Medical Examiner.
Date signed 8/26/46

G43276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74A

Registered No. G43276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Frieden & Madeira Hosp
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
2-1 (d) Street No. 4 York Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine LeNoir Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1904

8. AGE: Years	Months	Days	If less than one day
41	9	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name John S. Taylor
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name E. H. Hoover
15. Birthplace Balto., Md.

16 (a) Informant Mr. John S. Taylor, father
(b) Address 4 York Court

17 (a) Burial, (b) Date thereof 8/30/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Balto., Md.

19 (a) (b)
(Date rec'd by registrar)

AUG 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28th 1946, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19th 1946 to 8/28th 1946, and that I last saw her alive on 8/23th 1946.

Immediate cause of death: Pneumonia and bronchitis — Duration: 9 days
Due to: Acute Encephalitis
Due to: Toxemia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Gonzales M. D.
Address Maryland G. Hosp Date signed 8/29/46

VS 150

Must be certified
By MEDICAL EXAMINER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G43277

The accuracy of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore City, Maryland~~
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Horace Mitchell Raines.

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War II	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-19.

8. AGE: Years	Months	Days	If less than one day
33	10	16	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name William H. Raines
13. Birthplace Va. (Johnson Co.)

MOTHER
14. Maiden Name Anna Mitchell
15. Birthplace Balto. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 29 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-28- 1946, at 155 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-25 1946 to Aug-28 1946 and that I last saw h[illegible] alive on Aug-28 1946

I hereby certify that death was caused as stated below, to the best of my knowledge and belief.

	Duration
Principal cause of death: Respiratory failure,	
Cause antecedent	
Due to	
Due to	
Other Conditions CHR Alcoholism	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Reynolds
Address Johns Hopkins Hospital Date signed 29 August

For Dr C. J. Fabrikant, by Edward J. Mancini, M.D.

VS 150

The G43278

HELNICK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186B

Registered No. G43278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland. Redwood & Greene
(b) Street address ~~Hunterdon Hosp.~~
(c) Hospital or institution: University Hospital 7-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 W. Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Helnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1927

8. AGE: Years	Months	Days	If less than one day
19	1	29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Poultry Business

FATHER
12. Name Robert Helnick
13. Birthplace W. Va.

MOTHER
14. Maiden Name Bell Johnson
15. Birthplace W. Va.

16 (a) Informant Mrs. Bell Helnick
(b) Address 34 W. Montgomery

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location 4 & 9 Co. Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Hgts.

19 (a) Registrar Huntington Williams M.D.
AUG 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1946, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 19 46 to 8-28 19 46, and that I last saw h/m alive on 8-28 19 46.

Immediate cause of death: Cardio respiratory failure — Duration

Due to Lobar pneumonia

Due to Chronic tuberculosis

Other Conditions positive wkd

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: ~~Partial~~ Full and complete

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 22/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 20-46 at 10:45 A M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial (Specify type of place) While at work? yes
(e) Means of injury Box fell on head

23. Signature Chas L. Cronely
Address University Hosp. Date signed 8-27-46 M. D.

Howard J. Worthington, M.D.

VS 150

Please write the causes of death clearly and legibly. Physicians: please write age if exact information should be carefully supplied. This is especially important.

G43279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G43279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
3-2
(d) Street No. 1630 S. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis, Herbert Cleveland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lottie Pestridge Lewis

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Mar. 30, 1885

8. AGE: Years 61 Months 4 Days 30 If less than one day ____ hr. ____ min.

9. Birthplace Accomac, Va. (Town, county, and state)

10. Usual Occupation Captain

11. Industry or business Seafarer

FATHER
12. Name Revel Lewis
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie ?
15. Birthplace Virginia

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Greenmount & Barclay

18 (a) Funeral director H. Harvey Groshaw
(b) Address Greenmount, Md.

19 (a) AUG 29 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1946, at 3:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1946 to Aug. 29 1946, and that I last saw him alive on Aug. 29 1946

Immediate cause of death (1) Hemorrhage, cerebral — Duration 3 days

(2) Hypertensive cardiovascular disease — UNKNOWN

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 8/29/46

VS 150

The information should be carefully supplied. The causes of death clearly and legibly. Physicians: please write the

G43280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. ~~Eaton Ave~~ 20-6 Lanvale (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Dora E. Priebe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rudolph Robert Priebe

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 29 1888

8. AGE: Years 62 | Months — | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Albert F. Schmidt
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie —
15. Birthplace Maryland

16 (a) Informant Mrs. Ralph Priebe
(b) Address 528 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. B. Hilgartner & Son
(b) Address 300 Eutaw Place

19 AUG 29 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1946, at 10 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1946 to 8-27 1946 and that I last saw her alive on 8-27 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions Bronchial pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hemyetta Hollies M. D.

Address Date signed 8/28/46

VS 150

Fill in all items if possible. Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G43281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G43281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 E Baltimore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry R. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 136-12-5320

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Jeanetta
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1903

8. AGE: Years	Months	Days	If less than one day
43	3mt	17	hr. min.

9. Birthplace Dayton, Ohio
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel S. Brown
13. Birthplace Harding County, Ohio

MOTHER
14. Maiden Name Dora Hughes
15. Birthplace Harding County, Ohio

16 (a) Informant Doris Brown
(b) Address 1612 E. Baltimore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Aug. 11th

(c) Cemetery or crematory St. Matthews
Location Edmondson Ave.

18 (a) Funeral director Randell & Pepper
(b) Address 312 S. Highland Ave

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.
Registrar

DEC 20 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26/46 19 , at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8/27/46

G43282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1008

G43282 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Collington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/84

8. AGE: Years	Months	Days	If less than one day
63	1	15	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert L. Smith
13. Birthplace Balto

MOTHER
14. Maiden Name Ida E. Crisp
15. Birthplace Balto.

16 (a) Informant Mrs. Lindeman(sister)
(b) Address 6 S. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell Street

18 (a) Funeral director Tully & Zeiler Co.
(b) Address 403 S. Wolfe Street

1946 AUG 29 (Date registered) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946, at 4 P. M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes [x] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
External hemorrhage
Thrombophlebitis
Chronic cellulitis

Due to (a)

Other Conditions Irregular ragged wound.
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallett M.D. Medical Examiner.
Date signed 8-28-46

FG43283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G43283

Please answer all questions. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 East North Ave. #2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Leo McKenna

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 18 - 1878

8. AGE: Years	Months	Days	If less than one day
68	—	11	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation INSPECTOR - BALTO. CITY
11. Industry or business HIGHWAY DEPT.

FATHER
12. Name JOHN C. McKENNA
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name MARY J. CAHAGAN
15. Birthplace BALTIMORE, MD.

16 (a) Informant CATHERINE E. McKENNA
(b) Address 730 E. NORTH AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans - Sons
(b) Address 118 W. Mt. Royal Ave

19 (a) AUG 29 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1946, at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 3 1946 to August 28 1946 and that I last saw him alive on August 28 1946.

Immediate cause of death
(a) Coma
Due to (b) Cerebral Thrombosis + Left Hemiparesis
Due to (c)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maynard Lynch
Address Maryland Gen. Hospital Date signed 8/29/46

VS 150

G43284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G43284 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 896 Washington Blvd
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Mold (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Hammonds Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Female Broseker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 25 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Roland Broseker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Kathryn Abend
15. Birthplace Baltimore Md.

16 (a) Informant
(b) Address 325 Hammonds Lane Brooklyn

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 29 1946 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1946, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death Pernat uraty — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Egan M. D.
Address 896 Washington Blvd Date signed 8/27/46

VS 150

G43285 BCH G 54526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1617

G43285 Registered No.

Please write the causes of death clearly and legibly. Physicians: please state if deceased was employed in any specially important, dangerous or unhealthful occupation. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 20
(e) Length of stay in Baltimore (yrs., mos., or days) 1 20 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Lyndale ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Verna Baugher.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23d 1946

8. AGE: Years | Months | Days | If less than one day 1 hr. 20 min.

9. Birthplace Maryland, Gen Hosp. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Vernon Roberts Baugher
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Doris Mae Smith
15. Birthplace Bague N.C.

16 (a) Informant Mother
(b) Address 3323 Lyndale ave. (Mary. Gen Hosp)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address
AUG 29 1946 (Local Registrar) Hamilton C. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 am 8/25 1946 to 12 m 8/25 1946, and that I last saw h alive on 8/25 1946.

Immediate cause of death	Duration
Atelectasis.	
Due to 5 mo fetus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

73. Signature C. D. Stowe, M.D.
Address Maryland Gen Hosp. Date signed 8/25/46

VS 150

G13286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V61

G13286
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address WEST BALTO. HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6001 EASTERN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Will.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife BERTHA M. DIEMILLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 12 - 1884

8. AGE: Years 62 Months 6 Days 14 If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation Dairyman

11. Industry or business

FATHER
12. Name JULIUS
13. Birthplace GERMANY

MOTHER
14. Maiden Name AUGUSTA KREIMEYER
15. Birthplace BALTIMORE.

16 (a) Informant WIFE
(b) Address 6001 EASTERN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location 7275 EASTERN AVE

18 (a) Funeral director CLARENCE F. HOFFMAN
(b) Address 1639 BROADWAY

19 (a) (b) Huntingtown Williamsport, Md.

AUG 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1946, to Aug 26 1946, and that I last saw him alive on Aug 26, 1946

Immediate cause of death Myocardial infarction — Duration 4 days

Due to Coronary Arteriosclerosis + Diabetes

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Gubrintsky M. D.
Address West Balto. Sem Hosp Date signed Aug 26, 46

PHYSICIAN

Underline the cause to which death should be charged statistically.

94A

Please write the information should be carefully supplied. Physicians: please write the ages is especially important. Physicians: please write the to the causes of death clearly and legibly.

G43287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G43287

Please write plainly with pen or pencil. The information must be carefully supplied. The physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 E. Main
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dora M. Cover

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Harry Cover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9-1860

8. AGE: Years	Months	Days	If less than one day
86	6	25	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name William Hitchens
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (a) Informant Eleanor Babylon
(b) Address Westminster, Md.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Aug. 31-1946 (month) (day) (year)
(c) Cemetery or crematory Lower Pine Lawn
Location Uniden Cem. Westminster, Md.

18 (a) Funeral director H. Bankard & Son
(b) Address Westminster, Md.

19 (a) AUG 29 1946 Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH Aug. 29, 1946 at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1946 to Aug. 29 1946 and that I last saw her alive on Aug. 28 1946.

Immediate cause of death	Duration
Bronchial pneumonia	4 days
Due to Advanced Arteriosclerosis	?
Due to	
Other Conditions Myocarditis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thalton S. Willis
Address 2220 Garrison Blvd. Date signed 8/29/46

VS 150

G43288

498774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V13B

Registered No. G43288

Please write the information should be carefully supplied. The importance of the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Powell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-14

8. AGE: Years	Months	Days	If less than one day
31	11	17	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Burl Cooley
13. Birthplace N. C.

MOTHER
14. Maiden Name Maggie Johnson
15. Birthplace N. C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Baltimore.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-1-46 (month) (day) (year)
(c) Cemetery or crematory Immaculate
Location Rocky Mount N. C.

18 (a) Funeral director Bryant Mamie F. Wright
(b) Address 721 Asquith St.

19 AUG 30 1946 (Signature) Registrar

VS 15a AUG 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946 at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1946 to Aug. 27 1946 and that I last saw her alive on Aug. 27 1946

Immediate cause of death: ACUTE MILIARY TUBERCULOSIS, GENERALIZED — Duration: 6-7 MONTHS OR LESS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: AS ABOVE
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Maxwell Williams M. D.
Address Johns Hopkins Hospital Date signed 8-27-46

over

X

G13289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G13289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural - Glyndon (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Frank Henze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race wh.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs Frank Henze

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 22 - 1890

8. AGE: Years 55 Months 10 Days 7 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Care Taker

11. Industry or business

FATHER
12. Name Johannes Henze
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Hohtruf
15. Birthplace Germany

16 (a) Informant Mrs Frank Henze
(b) Address Glyndon - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/31/46 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address St. Paul St

19 (Date rec'd by registrar) AUG 30 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1946, at 2 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1946 to Aug 29 1946, and that I last saw him alive on Aug 29 1946

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertensive C-V Dis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George H. Lehmann M.D.
Address Union Memorial Hosp Date signed 8/30/46

VS 150

Please answer all questions as far as information should be carefully supplied. The questions are especially important. Physicians: please write the causes of death clearly and legibly.

G43290 over

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 159 ✓ G43290 Registered No.

The information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6½ hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bon Secours Hospital
(If rural give location)
7525 Belair Rd
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paemature Girl Shifflet

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8/29/46

8. AGE: Years 0 | Months | Days | If less than one day 6 hrs 30 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Warren Winston Shifflet
13. Birthplace Va.

MOTHER
14. Maiden Name Melbina Frances Taylor
15. Birthplace Balto. Md.

16 (a) Informant Irvin Shifflet
(b) Address 7525 Belair Rd

17 (a) Burial (b) Date thereof 8/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date received by registrar) AUG 30 1946 Cutler for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1946, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-1946, to 8-29-1946, and that I last saw her alive on 8-29-1946.

Immediate cause of death: Respiratory paralysis — Duration
Due to: Prematurity - 6 mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Cook M.D.
Address 1217 St. Paul St. Date signed

VS 150

G43291 — AB-108064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

G43291 — Registered No.

Important: Information should be carefully supplied. The spaces especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 27-5
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3421 Rosalie Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Maul

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 84?

8. AGE: Years	Months	Days	If less than one day
84?	?	?	hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 31 46 (month) (day) (year)
(c) Cemetery or crematory St Johns Luth. Cem
Location Balto Co. Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 30 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 1946, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1946 to 8-28- 1946.
and that I last saw h im alive on 8-28- 1946.

Immediate cause of death: Respiratory failure — Duration
Due to Bronchopneumonia
Due to
Other Conditions A S H D. Chronic hypertension retention, malnutrition
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Walker M. D.
Address B. C. H. Date signed Aug. 28 1946

107

G43292 ✓ G43292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 839

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write all information required. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1513
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Dunlight Rest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town, write RURAL and give town)
(d) Street No. 1814 Whitmore Ave
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary (Nannie) Long Nash.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank S. Nash
6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Nov 11 1858

8. AGE: Years 87 | Months 9 | Days 18 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (town, county, and state)

10. Usual Occupation: Housework.

11. Industry or business: Home

FATHER
12. Name: Samuel Long.
13. Birthplace:

MOTHER
14. Maiden Name: Georgiana Gantt
15. Birthplace:

16 (a) Informant: Mrs Ida Todd
(b) Address: 223 Berkley Ave Roland Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 31 1946 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore Md.

18 (a) Funeral director: Bertram Rose
(b) Address: 2224 N Charles St

19 (a) (Date rec'd by registrar) (b) Registrar: Lexington Williams, M.D.

AUG 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1946 at 10:42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1945 to Aug 29 1946 and that I last saw her alive on Aug 25 1946.

Immediate cause of death

	Duration
Cerebral Hemorrhage	10 days
Due to Arteriosclerosis	12 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature: Mrs Ida Todd
Address: 2108 St Paul St Date signed: 8/29/46 W D.

X

G43293 — JL - 103808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G43293

Type or use ink. Information should be carefully supplied. Physicians: please write especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Nursery Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1873

8. AGE: Years 72 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Amos
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31/46 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Taylor Ave.

18 (a) Funeral director Edmund C. Donovan
(b) Address 3615-17 Edmondson Ave

19 AUG 30 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1946 3:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1946 to Aug 28 1946 and that I last saw h im alive on Aug. 28 1946.

Immediate cause of death: Subdural (Frontal) hemorrhage — Duration: 3 days
Due to: Arteriosclerosis — 4 yrs.
Due to: Rt. upper & lower bronchopneumonia — 2 days
Other Conditions: Aortic & mitral stenosis
(Include pregnancy within 3 months of death)

Date of operation 8-23-46
Major findings of operation: Fibrosis of prostate & obstruction
of autopsy: Cardiac

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Jones M. D.
Address Balto City Hospitals Date signed 8-29-46

VS 150

G13294

497309.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G13294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. County
(c) City or town Ruthrieum Heights.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Greenwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brohawn (Mary G. Brohawn)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-46

8. AGE: Years 0 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Brohawn
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Frances ROSIER
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto City

18 (a) Funeral director Prott & Bm Walter
(b) Address Prott, Clarke & Sons.

19 AUG 30 1946 (c) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1946 at 3.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June July 18 1946 to Aug-29 1946 and that I last saw h er alive on Aug-29 1946

Immediate cause of death

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Sheldon M. D.
Address Date signed 7/29/46

Please write the causes of death clearly and legibly. Physicians: please give especially important. Omission or misstatement of information should be carefully supplied. The

G43295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

Registered No. G43295

Please write the information asked for clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 N. WOLFE ST.
(c) Hospital or institution: 7-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 N. WOLFE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MEYER GRODNITZKY

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife SARAH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 29-1879

8. AGE: Years	Months	Days	If less than one day
67	-	-	hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation GROCERY STORE
11. Industry or business

FATHER
12. Name SAMUEL GRODNITZKY
13. Birthplace RUSSIA

MOTHER
14. Maiden Name GUSSIE
15. Birthplace RUSSIA

16 (a) Informant MISS GUSSIE GRODNITZKY
(b) Address 839 N- WOLFE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-30-46 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL. RD. + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 GUTAW PLACE

19 AUG 30 1946 (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 29 1946, at 6.17 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 19 44 Aug. 29 19 46 and that I last saw him alive on Aug. 29 1946.

Immediate cause of death — Duration

Ac Cardiac Collapse 1hr

Due to

Due to Hypertension, Hypocardia 3yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Boardman M.D.
Address 2040 Gutaw Date signed 8/29/46

VS 150

X

G43296 BALTIMORE CITY HEALTH DEPARTMENT G43296

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Ferndale Ave.
(c) Hospital or institution:

28-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Ferndale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADA R. COLEIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1868

8. AGE: Years	Months	Days	If less than one day
78	5	24	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation --
11. Industry or business --

FATHER
12. Name William H. Colein
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Yates
15. Birthplace Maryland

16 (a) Informant Mrs. Minnie C. Vane
(b) Address 3305 Ferndale Ave.

17 (a) Burial (b) Date thereof 8/31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 30 1946 Registrar
Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1946, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Aug 29 1946 and that I last saw her alive on Aug 27 1946

Immediate cause of death Respiratory failure

Due to Arteriosclerotic Cardiovascular renal dis

Due to

Other Conditions femoral grubbles (arterial)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Shorb M.D.
Address 601 N. Monroe St Date signed 8/29/46

Please write the causes of death clearly and legibly. Physicians: please state as especially important. The information should be carefully supplied.

G43297

CWK-104055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

125B

G43297 Registered No.

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The accuracy of this certificate is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 264
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 152 N. Haven Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Boblitz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10-1892

8. AGE: Years	Months	Days	If less than one day
54	2	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Boblitz
13. Birthplace Maryland

MOTHER
14. Maiden Name Lou Sonnie
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Aug. 31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location E. Pennell St.

18 (a) Funeral director John L. Miller
(b) Address 2324 Jefferson St.

19 (a) Huntington Station
(Date rec'd by registrar)

VS 1 AUG 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1946, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1946 to Aug. 29 1946, and that I last saw him alive on Aug. 29 1946.

Immediate cause of death: Respiratory Failure — Duration

Due to: Acute Hepatitis ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. R. Hearn M. D.
Address Balto. City Hosp. Date signed 8-29-46

G43298 (struck: G43298 82)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No. G43298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Decatur — (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Canal St — (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Bell —
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced —
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-16-96

8. AGE: Years 50 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation missionary
11. Industry or business

FATHER
12. Name Harry R. Bell —
13. Birthplace Indiana —

MOTHER
14. Maiden Name Florence Appleby
15. Birthplace Tennessee —

Records.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 30, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location On Line between Linn and

18 (a) Funeral director Williams Cook, Inc
(b) Address 1217 St. Paul Street

19 (a) Huntington Williams Mgr.
(Date received by Registrar) AUG 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1946 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1946 to Aug 29 1946 and that I last saw her alive on Aug 29th 46

Immediate cause of death: Shock, postoperative — Duration 6 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-29-46

Major findings of operation: Tumor, pelvic adhesions, suppurating ovarian cysts, salpingitis

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Huggins M.D.
Address Johns Hopkins Hospital Date signed Aug 30 46

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

Sites ✓

G43299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

459

G43299 Registered No.

Please write information should be carefully supplied. The Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 E. 20th Street
(c) Hospital or institution:
12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Philip Sites

3 (b) If veteran, name war

3 (c) Social Security Account No. 210-11-8959

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Addie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 8-1887

8. AGE: Years 59 | Months 6 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, County, and State)

10. Usual Occupation Bench Guard

11. Industry or business

FATHER
12. Name Edward F. Sites
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Whitehead
15. Birthplace Baltimore Maryland

16 (a) Informant Natalie Jr. Behrle
(b) Address 438 E. 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31-1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount Ave. & North Gate

18 (a) Funeral director Joseph Sarace Inc.
(b) Address 2013 Greenmount Ave

19 (a) AUG 30 1946 Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29th. 1946 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27th. 1946 to Aug. 29th. 1946
and that I last saw him alive on Aug. 27th 1946.

Immediate cause of death: Carcinoma of angle of left jaw — Duration: 3 mos.

Due to: unknown

Due to: ---------

Other Conditions: ---- - -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. W. Montgomery M.D.

Address 401 E. 25th. St. Date signed 8/30/46. M.D.

X

643500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

643500 Registered No.

Please answer all questions in full. Any information should be carefully supplied. The accuracy of information is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. ~~Sex~~ Female

5. Color or race B

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887 - Oct. 5,

8. AGE: Years 58 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Jones.
13. Birthplace Ga.

MOTHER
14. Maiden Name Sula Ware.
15. Birthplace Ga.

16 (a) Informant Eva Thigh
(b) Address 606 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St Waverly, Md.

19 ~~AUG 30 1946~~ (Date filed by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1946, at 4 45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1946, to Aug 27 1946, and that I last saw h Pr alive on Aug 27 1946.

Immediate cause of death	Duration
Generalized Arteriosclerosis	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Campbell M. D.
Address 722 W. Fulton Ave Date signed 8/27/46

VS 180

X

G43301 BC# B53948 GARY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G43301 Registered No. 24747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 W. Conway St.
(c) Hospital or institution: 22

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 W. Conway St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gary Lionel Berry

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1946

8. AGE: Years	Months	Days	If less than one day
0	0	17/6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Joseph Berry
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ella Lee Dukes
15. Birthplace Manning S.C.

16 (a) Informant Mother
(b) Address 601 W. Conway St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Fayette St

19 AUG 30 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1946, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12, 1946, to Aug. 28 1946, and that I last saw he alive on Aug. 28, 1946.

Immediate cause of death Broncho-Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature RB Lighton
Address 501 Cherry Hill Rd Date signed M. 8/28/46 D.

X

G43302 G43302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 W. Hoffman St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1908

8. AGE: Years	Months	Days	If less than one day
38	5	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Balto. Fruit Exchange

11. Industry or business Camden Station

FATHER 12. Name John Wesley Hall

13. Birthplace Baltimore Maryland

MOTHER 14. Maiden Name Maggie Smith

15. Birthplace Baltimore Maryland

16 (a) Informant Williams' Luben

(b) Address 317 Hoffman Street

17 (a) Burial (b) Date thereof 8/31/46.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery [redacted] Mt. Auburn.

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) AUG 30 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946, at 11 30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema, hypertrophy and dilatation of heart, acute fatty degeneration of liver, edema of brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Measures M.D.
Medical Examiner.

Date signed 8-28-46

VS 191

643.03 Schlessinger

BALTIMORE CITY HEALTH DEPARTMENT X 94a Registered No. 643.03

CERTIFICATE OF DEATH

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2032 Eutaw Pl
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C (b) County Washington
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Conrad Schlessinger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-20

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/46 (month) (day) (year)

(c) Cemetery or crematory
Location Washington D/C

18 (a) Funeral director Sol Wm Finck
(b) Address 811 N Wolfe St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 30 1946 Washington Millesville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1946 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1946 to Aug 30 1946, and that I last saw h[illegible] alive on Aug. 28/46

Immediate cause of death — Duration
Coronary Occlusion 2 hrs
Due to
Due to Myocardial Infarction 1 D

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 2040 Eutaw Pl Date signed Aug. 30-46

G43.04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 ✓ G43.04 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N. Caroline St.
(c) Hospital or institution: 7-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 715 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Wright ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widower.

6 (b) Name of husband or wife Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years About 57 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (East Island) (Town, county, and state)

10. Usual Occupation Gardener (Shipyard)

11. Industry or business

FATHER 12. Name Simon Wright
13. Birthplace Md

MOTHER 14. Maiden Name Mary Davis
15. Birthplace Md

16 (a) Informant Helen Watkins
(b) Address 715 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location

18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Carrollton Ave.

19 AUG 30 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28. 1946 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Aug 28 1946, and that I last saw h[illegible] alive on Aug 26 1946.

Immediate cause of death respiratory failure
pneumonia (bronchial)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
2 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell
Address 1M Aisquith Date signed 8-30-46

VS 180

X

G43305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43305 ✓ Registered No. 939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Druid Hill Ave D.O.A.
(c) Hospital or institution: 14-✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Holland

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/1909

8. AGE: Years	Months	Days	If less than one day
35 36	10	5	hr. min.

9. Birthplace Eastern Shore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Gregg
13. Birthplace Md

MOTHER 14. Maiden Name Josey Hopkins
15. Birthplace Md.

16 (a) Informant Thelma Louis
(b) Address 1608 Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (month) (day) (year)
(c) Cemetery or crematory Bellevue, Md
Location Eastern Shore

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 (a) 8-30-1946 (Date received by local registrar) (b) Huntington Williams, M.D. (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1946 5:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hos death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis Degeneration

Due to

Other Conditions Congenital Heart Deformity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sullivan M.D. Medical Examiner.
Date signed 8/29/46

VS 181

643306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

643306 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-3
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Thames St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Lisek

3 (b) If veteran, name war: no 2

3 (c) Social Security Account No. 212-12-5652

4. Sex M 5. Color or race W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Born Jan 28 1908

8. AGE: Years 43 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Balto md. (Town, county, and state)

10. Usual Occupation Plumber helper

11. Industry or business James Andrews

FATHER 12. Name John Lisek

13. Birthplace Poland

MOTHER 14. Maiden Name Maryanna Matsouski

15. Birthplace Poland

16 (a) Informant Mrs. Maryanna Lisek

(b) Address 1625 Thames St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rood Cem.

Location German Hill Road

18 (a) Funeral director Marie E. Fiathowski

(b) Address 1800 E. Kenwood Ave

19 (a) Aug 31 1946 (Date received by registrar) Municipal Williams

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1946, at 7:45 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William F. Kelly M.D. Medical Examiner

Date signed 29 Aug 46

G43307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56

Registered No. G43307

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 S. Dallas St.
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 S. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy A. Lamka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day: hr.	min.
23				

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anthony Carullo

13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Piccarello

15. Birthplace Italy

16 (a) Informant Frank Lamka

(b) Address 520 S. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. City

18 (a) Funeral director Wm. L. Stallkrawsher

(b) Address 2007 Eastern Ave

19 (a) AUG 30 1946 (Date rec'd by registrar) Huntington-Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to Aug. 29 1946. and that I last saw her alive on Aug. 29 1946

Immediate cause of death: Tumor of Uterus (Left Inguinal region) — Duration 8 mos.

Due to (Uterus)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John V. Szymbrske M. D.

Address 1802 Eastern Ave Date signed Aug 30 46

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN. G43308 104105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G43308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14 th 1878

8. AGE: Years	Months	Days	If less than one day
68	0	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Ambrose Hertman (?
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy (?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John G Connelly.
(b) Address 448 Eastern Ave. Cand 21

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

VS 188 AUG 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29th 1946, at 3.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 28th 46 to Aug. 29 19 46 and that I last saw h him alive on Aug. 29th 19 46

Immediate cause of death: Coronary Occlusion.

Due to Hypertension & Arterio-sclerotic C-V Disease

Due to Congestive Failure.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: /

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Farber
Address Balto. City Hospitals Date signed 8-29-46 M. D.

X

Every item of information should be carefully supplied. The Physicians; please write the causes of death clearly and legibly.

Dr. Anthony Thomas

G43309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Ailsa Avenue
(c) Hospital or institution: 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Ailsa Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Schirm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Sallye L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9. 1872

8. AGE: Years 74 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Court House

11. Industry or business

FATHER 12. Name Frederick Schirm
13. Birthplace Austria

MOTHER 14. Maiden Name Louise Hess
15. Birthplace Austria

16 (a) Informant Mrs. Sallye Schirm
(b) Address 3010 Ailsa Avenue, -14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 30 1946

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Aug 29 1946, and that I last saw him alive on Aug 28 1946.

Immediate cause of death: Pulmonary edema — Duration: 6 hours

Due to Cerebral hemorrhage — 3 weeks

Due to Asteriosclerotic Cardiovascular disease — 8 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J Thomas M. D.

Address 4600 York Rd Date signed 9/30/46

Physician is especially important. Physicians: please write the causes of death clearly and legibly.

G43310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G43310

Every item of information should be carefully supplied. The space for Physicians is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 W. Univerity Pkwy 1
(c) Hospital or institution:
12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 W. University Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annette Virginia Koch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years: About 70 ? Months: Days: If less than one day: hr. min.

9. Birthplace Baltimore, Md
None (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Koch
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine H. Stalfort
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Katherine Leidenroth
(b) Address 110 W. University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30, 46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (Date received by registrar) AUG 30 1946 Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1946, at 8 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to 28 Aug 1946, and that I last saw her alive on 28 Aug 1946.

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions: Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Hefford M. D.
Address 5006 Roland Ave. Date signed 30 Aug 46

VS 150

X

G43311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registration No. G43311

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-V
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Warner St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Coles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 1911

8. AGE: Years	Months	Days	If less than one day
35	2	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Richard

FATHER
12. Name Reverend Thomas
13. Birthplace Unknown Md

MOTHER
14. Maiden Name Mary West
15. Birthplace Md Maryland

16 (a) Informant Laula [illegible]
(b) Address 608 Warner Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Isaiah D Brown Son
(b) Address 1058 Montgomery Street

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 30 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27th 1946, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1946 to 8/27 1946, and that I last saw h er alive on Aug 26 1946.

Immediate cause of death	Duration
Intestinal Obstruction & Cachexia	3 wks.
Due to Intra-abdominal mass	8 yrs.
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Aug. 24, 1946
Major findings of operation: Found filled cyst of malignant characteristics
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John E. Morrison
Address University Hosp. Date signed 8/27/46 M. D.

X

G43312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43312

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 East 28 St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 East 28 St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Schaeffer

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Minnie B.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 2 JAN. 1861

8. AGE: Years	Months	Days	If less than one day
85	7	26	hr. / min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William H. Schaeffer
13. Birthplace Maryland.

MOTHER 14. Maiden Name Cecelia Hallen
15. Birthplace Maryland.

16 (a) Informant Mr. W. J. Stultz
(b) Address 113 Ingelside Ave - Catons

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 31 Aug 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. B. Shubert & Son
(b) Address 1300 Eutaw Place

19 (a) (Signature of registrant) (b) Registered Aug 30 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug. 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1946 to Aug 28 1946 and that I last saw him alive on Aug 28 1946.

Immediate cause of death: myocardial insufficiency — Duration 6 days
Due to Arteriosclerosis — 20 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur J. Davis M. D.
Address 800 W. - 33rd St. Date signed 8/29/46

X

G43313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B Registered No. G43313

Type or print PERMANENT RECORD in INDELIBLE INK. Entries must be made as completely as possible. The information should be carefully supplied. The questions are important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Phillip Snure SNWRR

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-09-8018

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie L. Snure

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1877

8. AGE: Years 68 | Months 11 | Days 15 | If less than one day: hr. min.

9. Birthplace Middletown Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Crown Cork & Seal

FATHER
12. Name Simon P. Snure
13. Birthplace Middletown Md.

MOTHER
14. Maiden Name Ella Steinbel
15. Birthplace Germantown Ohio

16 (a) Informant Mrs Minnie L Snure
(b) Address 1117 E North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Green Hill
Location Waynesboro Penna

18 (a) Funeral director Easter Sons
(b) Address Elliott City Md.

AUG 30 1946
(c) Name of local registrar Huntington Williams
AUG 31 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1946 at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1946 to 8/29 1946 and that I last saw h.M alive on 8/28 1946.

Immediate cause of death

Carcinoma of Cancer of Bladder

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Jere Bauman M.D.

Address 1250 E 34th St Date signed 8/31/46

X

G43314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G43314 Registered No.

Type or print all information should be carefully supplied. The cause of death is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & Slat St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Cleveland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1693 Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Soytz, Aloysius

3 (b) If veteran, name war

3 (c) Social Security Account No. 295-10-3212

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1893

8. AGE: Years	Months	Days	If less than one day
53	5 6	17	hr. min.

9. Birthplace Cleveland, Ohio
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name D. Soytz
13. Birthplace Germany

MOTHER
14. Maiden Name Stella Krisha
15. Birthplace Germany

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-46 (month) (day) (year)
(c) Cemetery or crematory Lavona
Location Lavona Baltimore Md

18 (a) Funeral director Elder Funeral Home Inc
(b) Address 4644 York Road
(c) Name Huntington Williams Mgr

AUG 31 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1946, at 6:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1946, to Aug. 29 1946 and that I last saw h im alive on Aug. 29 1946.

Immediate cause of death (1) Thrombus, bifarction of abdominal aorta, Postoperative gastrostomy — Duration LESS than 13 days
Due to (2) Carcinoma of esophagus with metastasis to adrenals, kidney and liver — Duration UNKNOWN

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert H. Englen M.D.
Address SA Surgeon Date signed 8/30/46
US Marine Hospital, Balto, Md.

VS 150

G43315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46E (WA)

Registered No. G43315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument + Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, or days) 23
(e) Length of stay in Baltimore (~~yrs.~~ ~~mos.~~, or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Nemucco Co.
(c) City or town Salisbury (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 1/2 Russel ave. (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME (Clinton E. Stone) EDWARD CLINTON STONE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Blossom Stone
6 (c) If alive, give age: 27 years
7. Birth date of deceased (mo., day, yr.) 8-18-14
8. AGE: Years 32 | Months 0 | Days 1 | If less than one day: hr. ___ min. ___
9. Birthplace Montclair, N. J. (town, county, and state)
10. Usual Occupation
11. Industry or business: Plant Rupt

FATHER
12. Name Edward Stone
13. Birthplace Newton, Mass.

MOTHER
14. Maiden Name Mabel Matlock
15. Birthplace Brooklyn, N. Y.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8 31 46 (month) (day) (year)
(c) Cemetery or crematory Mount Hebron
Location Montclair, N. J.
18 (a) Funeral director Wm. J. Leatherbury Sons Inc.
(b) Address Northern Parkway Cross (71)
19 AUG 31 1946 (Date rec'd by local reg.) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1946 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1946 to 8-30 1946 and that I last saw h[illegible] alive on 8-30 1946.

Immediate cause of death: Circulatory Collapse — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within three months of death)
Date of operation 16 August 46
Major findings of operation: Cancer of Transverse Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Barnett Higgins Jr. M.D.
Address Johns Hopkins Hosp. Date signed 30 Aug 46

VS 150

G43316 — BALTIMORE CITY HEALTH DEPARTMENT — G43316

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 N Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles J Schuchardt

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None
4 Sex: Male
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Emma O Kaiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11 1870

8. AGE: Years 75 | Months 10 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Master Plumber retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Calvin G Lambert
(b) Address 1607 Northwick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 N Gay St

19 (a) (b) Washington Williams

Filed SEP 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1946, at 5:50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 24 1946 to Aug 30 1946 and that I last saw h[illegible] alive on 8/29 1946.

Immediate cause of death: Carcinoma Rectum with Metastasis Liver — Duration 6 mo
Due to Acute Heart failure Original
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation May 14 1946
Major findings of operation: Carcinoma Rectum with metastasis
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Luther E Leiter M.D.
Address 10 W. Madison St Date signed 9/3/46

Physicians: please write the causes of death clearly and legibly. Information should be carefully ... especially important.

G43317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G43317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 W Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha C. Richards

3 (b) If veteran, name war	3 (c) Social Security Account No.
	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Christ W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15. 1863

8. AGE: Years	Months	Days	If less than one day
83	5	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name	George Filbert
FATHER 13. Birthplace	Baltimore Md
MOTHER 14. Maiden Name	Catherine Hammp
MOTHER 15. Birthplace	Baltimore Md

16 (a) Informant Mr Samuel R Touchie
(b) Address 1405 W Fayette St
17. Burial (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Wilson & Lee
(b) Address 1219 E Pratt St
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 31 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/46 1940 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Epithelioma face

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 8/30/46

G43318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Pine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

17-1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK J. R. ROBINSON

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 218-10-9042

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1893

8. AGE: Years 53 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robinson
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mrs. Marie Dorsey
(b) Address 425 N. Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-46 (month) (day) (year)
(c) Cemetery or crematory New National Cem.
Location Baltimore Md

18 (a) Funeral director Mrs. Frances A. Hensley
(b) Address 578 W. Lanvale Street

Filed (Date) AUG 31 1946 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1946, at 8A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1946 to 8-29 1946 and that I last saw h[illegible] alive on 8-27 1946

Immediate cause of death: Hypertension Cardiac Decomp — Duration: 1 yr
Due to Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 525 Dolfield Ave Date signed 8-30-46

X

VS 150

Physicians: please write the causes of death clearly and legibly. Information should be carefully written on this certificate is especially important.

G43319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G43319

Please write the cause of death clearly and legibly. Physicians: please report as specifically important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road
(c) Hospital or institution: Snyder Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Loch Raven Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma George

3 (b) If veteran, name war: —
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles A George
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Apl. 13 1872
8. AGE: Years 74 Months 4 Days 16 If less than one day ____ hr. ____ min.
9. Birthplace Baltimore County Md (Town, county, or state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William M Boone
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Harriett Gallaway
15. Birthplace Baltimore Co Md

16 (a) Informant Mrs Clara Hood
(b) Address 4713 Park Ave

17. Burial (Burial, cremation, or removal) (b) Date thereof 8/31/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore County Md

18 (a) Funeral director Wilson & Son
(b) Address 1548 E Fort Ave

19 (a) AUG 31 1946 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1946 at 3:21 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1937 to 8/29 1946 and that I last saw [illegible] alive on 8/29 1946

Immediate cause of death: Carcinoma of R. breast — Duration: 2 years
Due to: Pulmonary metastasis
Due to: Ca. of breast — 14 months
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 8/12/39
Major findings of operation: Ca of R. breast
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature R. A. Michelson M.D.
Address 2270 Eutaw Pl Date signed 8/30/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G43320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43320 Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. Physicians: please w

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 364 Marydell Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 364 Marydell Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin J. Sheats

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah L. Sheats
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1874

8. AGE: Years	Months	Days	If less than one day
72	4	24	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business

FATHER
12. Name Thomas Sheats
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Barrett
15. Birthplace Md.

16 (a) Informant Mrs. Sarah L. Sheats
(b) Address 364 Marydell Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood A
Location Baltimore Co., Md.

18 (a) Funeral director E. I. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

AUG 31 1946 (Date rec'd by Registrar) (b) Interring for Williams M.D.

MEDICAL CERTIFICATION 2.00

20. DATE OF DEATH August 28, 1946, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to 8/28 1946
and that I last saw him alive on 8/26 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Cardio-Vascular Renal & Hypertension	6 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott W. Johnson M.D.
Address 2432 Frederick Ave. Date signed 8/29/46

VS 150

X

G43321 — BALTIMORE CITY HEALTH DEPARTMENT — G43321

CERTIFICATE OF DEATH 94a

Registered No.

Type or print all of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Ward 140. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 James St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Howard J. Tellis
3 (b) If veteran, name war No
3 (c) Social Security Account No. 212-09-5278
4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced. Clara Gibson
6 (b) Name of husband or wife Mary B
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Sept. 8 1880
8. AGE: Years 65 Months 11 Days 22 If less than one day hr. min.
9. Birthplace Va (Town, county, and State)
10. Usual Occupation Machinist
11. Industry or business American Can Co.

FATHER
12. Name John Tellis
13. Birthplace Va.

MOTHER
14. Maiden Name Clara Gibson
15. Birthplace Va.

16 (a) Informant Mary B. Tellis
(b) Address 1347 James St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dysart & Sons
(b) Address Lombard & Ann Sts.

19 (a) Filed AUG 31 1946 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1946, at 10:36 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 8-30 1946 and that I last saw him alive on 8-30 1946.
Immediate cause of death: Cardiac failure, Coronary Thrombosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Donald W. Mintus M.D.
Address St. Agnes. Date signed 8/30/46

G43322

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 1939

G43322

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Beech Hill Nursing Home-6028 Old Harford Rd.
Stay in hospital or inst. (yrs., or mos., or days): 18 Days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2870 Keatuky Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Edward P. Wolf

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	~~Single~~

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	1	21		

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business:

FATHER
12. Name: Edward L. Wolf
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Funk
15. Birthplace: Baltimore, Md.

16. Informant: Howard Bachman & Frederick Wolf
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/2/46 (Months) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18. Funeral director: M. W. E. Duffy's Sons
Address: Lombard & Hanover Sts.

AUG 31 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1946 at 4 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 12 1946 to Aug 29 1946 and that I last saw him alive on Aug 12 1946

Immediate cause of death	DURATION
Acute Hypostemic Cardio Vascular Disease	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. C. Post M.D.
M. D. or other
Address: 6805 York Rd
Date signed: 8/29/46

G43323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G43323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N Central Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leola Glenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1881

8. AGE: Years	Months	Days	If less than one day
65	-	13	hr. min.

9. Birthplace Mansfield Ga. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Westley
13. Birthplace Ga

MOTHER
14. Maiden Name Emma Hall
15. Birthplace Ga

16 (a) Informant Anna Sears
(b) Address 56 Emerson Ave N.Y.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location U.A. County Md.
18 (a) Funeral director Mrs. Kath A. Elliott Dft
(b) Address 1129 N. Caroline St.
19 (a) AUG 31 1946 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1946, at 12 45 p. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes, mellitus, Arteriosclerosis, Hypertensive cardiovascular disease with
Due to congestive failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haddaway M.D. Medical Examiner.
Date signed 9-28-46

VS 151

643524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

643524 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 MAYFIELD AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 2410 MAYFIELD AVE
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME CATHERINE M. SCHMIDT

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife ANDREW SCHMIDT
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAR. 20 - 1879

8. AGE: Years	Months	Days	If less than one day
67	5	10	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name NICHOLAS G. GROSS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name EVELYNE PALMER
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. JOSEPH IMBROGULIO
(b) Address 2410 MAYFIELD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 N. Mt. Royal Ave

19 (a) AUG 31 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION A.

20. DATE OF DEATH AUG. 30 1946 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1946, to Aug. 30, 1946, and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis — Duration: 15 minute

Due to: Arteriosclerosis — Unknown
Myocarditis — Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Grasso

Address 2942 E. Fayette St. Date signed 8/31/46

Dr. C. J. Lumsden By Howard Lumsden M. D.

G43325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 1697

G43325

Please answer all items. Information should be carefully supplied. The questions are especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Druestman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Druestman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nettie Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1892

8. AGE: Years 54 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Emporia, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Dunn
13. Birthplace Emporia, Va

MOTHER
14. Maiden Name Elizabeth Robinson
15. Birthplace Emporia, Va

16 (a) Informant Mrs. Mary Mann
(b) Address 1027 Fulton St. Brooklyn, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1691 Druid Hill Ave.

19 (a) AUG 31 1946 (Date rec'd by registrar) (b) Registrar Washington Whitehurst, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1- 1946, to 8-30-1946, and that I last saw h[illegible] alive on 8-29-1946.

Immediate cause of death: Carcinoma of intestines — Duration 7 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work) (Specify type of place)
(e) Means of injury

23. Signature Frank H. Saunders M. D.
Address 1029 N Stricker Date signed 8-30-46

VS 150

G43326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1214

Registered No. G43326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 Bloom St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~10 yrs~~ 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Bloom St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lula Belle Wynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced W. dow

6 (b) Name of husband or wife Nesta Wynn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1882

8. AGE: Years 64 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Starkville, Miss.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Lewis Bell
13. Birthplace Miss.

MOTHER
14. Maiden Name Louisiana Bell
15. Birthplace Miss.

16 (a) Informant Lula Simms
(b) Address Chicago.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) AUG 31 1946 (Date rec'd by registrar) (b) Thurston for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1946, at 3 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 19 46, to 8/29 19 46
and that I last saw h alive on 19

Immediate cause of death Cardiac Failure — Duration 1 day
Carbuncle - Upper Right Arm — 10 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Lorraine Tormey M. D.
Address 1100 Druid Hill Ave Date signed 8/30/46

VS 3

C43327

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C43327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Baker St D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cassandra Curtis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1896

8. AGE: Years	Months	Days	If less than one day
50	6	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin F. Douglas
13. Birthplace Kearney Co. Va

MOTHER
14. Maiden Name Mary A. Dennis
15. Birthplace Snow Hill, Md

16 (a) Informant Mrs. George R. Curtis
(b) Address 506 Baker St.

17 (a) Burial (b) Date thereof Sept. 1, 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md

18 (a) Funeral director Mrs. Geo. H. Hilleary
(b) Address 16 W. Druid Hill Ave

19 (a) AUG 31 1937 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1937, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Degeneration
Due to
Other Conditions Obesity
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/29/37

G43528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G43528

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Bolls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race N

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 3-22-15

8. AGE: Years 31 | Months 65 | Days 6 | If less than one day hr min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name William H. Tibbs
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary A. Tibbs
15. Birthplace Virginia

16 (a) Informant Joseph Bolls
(b) Address 902 madison ave.

17 (a) Removal (b) Date thereof 8/31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Blackstone, Virginia

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill ave.

19 (Signature of local registrar) AUG 31 1946 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1946, at 2 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1946, to 8-28 1946, and that I last saw her alive on 8-28 1946.

Immediate cause of death Auto intoxication — Duration

Due to Intestinal Obstruction

Due to Valvulus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-28-46

Major findings of operation: Intestinal Obstruction

of autopsy: Yes No

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. I. B. Higgins / Halsted M. D.

Address 1514 Division ST Date signed 8-31-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

X

643529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registrar's No. 643529

Typewriter or information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N Glover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N Glover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Koerner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1861

8. AGE: Years 85 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Rattman

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Koerner

(b) Address 22 N. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2 46 (Month) (day) (year)

(c) Cemetery or crematory Holy Red.

Location Belair Rd.

18 (a) Funeral director John G Moran

(b) Address 3000 E Baltimore St

19 (a) AUG 31 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1938 to Aug 30 1946 and that I last saw he alive on Aug 30 1946

Immediate cause of death	Duration
Arteriosclerosis, cerebral	
Due to Generalized arteriosclerosis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gould M. D.

Address 47 E Eager Date signed 8-30-46

G43330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55c

G43330 Registered No.

Please write the causes of death clearly and legibly. Physicians: please ... Accuracy and completeness of information should be careful...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves
(c) Hospital or institution St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 SEQUOIA A (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. ARTHUR PFEIFFER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife ADELAID P. Pfeiffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1893

8. AGE: Years	Months	Days	If less than one day
52	8	6	hr. min.

9. Birthplace (Balto) MARYLAND (Town, county, and state)
10. Usual Occupation Butcher Supplies
11. Industry or business Owner

FATHER
12. Name JACOB R Pfeiffer
13. Birthplace MD

MOTHER
14. Maiden Name ESTELLE McCENEY
15. Birthplace MD (A. A. Co.)

16 (a) Informant Mrs. Adelaide P. Pfeiffer
(b) Address 3817 Sequoia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 31 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1946, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1946 to 8-30 1946, and that I last saw him alive on 8-30 1946

Immediate cause of death (a) At-Operative Shock
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald W. Mintzer M.D.
Address St-Agnes Date signed 8/30/46

VS 150

G43331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 186a

Registered No. G43331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 Moravia Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Earl M. Dixon

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, (married), widowed, or divorced

6 (b) Name of husband or wife: Naomi F. Dixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1905

8. AGE: Years 41 | Months 7m | Days 29 | If less than one day hr. min.

9. Birthplace Utah (Payson) (Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business West. Elec.

FATHER
12. Name Martin Dixon
13. Birthplace Iowa

MOTHER
14. Maiden Name Rebecca Lant
15. Birthplace Payson, Utah

16 (a) Informant: Mrs. Naomi F. Dixon
(b) Address 3333 Moravia Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/31/46 (month) (day) (year)
(c) Cemetery or crematory
Location Salt Lake City, Utah

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by registrar: AUG 31 1946 (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Aug 1946 at 2.02 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Aug 1946 to 30 Aug 1946, and that I last saw him alive on 30 Aug 1946.

Immediate cause of death	Duration
Resp failure	
Due to Hypostatic pneumonia	
Due to Fract. 5th cervical vertebra	
Other Conditions quadraplegia,	

(Include pregnancy within 3 months of death)
Date of operation 4 Aug 46
Major findings of operation: Application of skull tongs
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4 Aug at ? M
(c) Where did injury occur? Mag River? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Mag River While at work? (Specify type of place)
(e) Means of injury Dove off boat into water

23. Signature R. M. H. Crosby
Address Univ. Hosp. Date signed 8/30/46 M.D.

Howard J. Mercer, M.D.

VS 150

Entry of item of information should be careful. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No. G43332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. G43332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Union Memorial Hosp.
(c) Hospital or institution:
33rd & Calvert St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Braddock Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. Jefferson Blvd. Box 1.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Richard Jeffers Rogers

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married.

6 (b) Name of husband or wife Mary Cook Rogers
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1867

8. AGE: Years	Months	Days	If less than one day
79	6	23	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name William H. Rogers
13. Birthplace New York City

MOTHER
14. Maiden Name Mary Jeffers
15. Birthplace New York City

16 (a) Informant Mrs Mary C. Rogers Smith
(b) Address Braddock Heights Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-46 (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Near Hyattsville Md

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W North Ave.

Filed SEP 3 1946 (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1946, at 89 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1946, to Aug. 31 1946, and that I last saw h[illegible] alive on Aug. 31 1946

Immediate cause of death

Pulmonary edema

Due to Lobar pneumonitis

Due to Arteriosclerosis

Other Conditions Heart disease

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul B. Towne, M. D.
Address Clear Mtn. Md. Date signed 8-31-46

VS 150

Every item of information should be carefully examined. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G43333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G43333 Registered No.

The entry of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.,
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 14, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Arlington Ave.,
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Joseph Fuchs

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/43

8. AGE: Years	Months	Days	If less than one day
3	6	2	14 hr. 15 min.

9. Birthplace Jacksonville, Florida
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Joseph Fuchs
13. Birthplace Maryland

MOTHER
14. Maiden Name Verda L. Reisz
15. Birthplace Maryland

16 (a) Informant Joseph A. Fuchs
(b) Address 2500 Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1946 (month) (day) (year)
(c) Cemetery or crematory Dashwood
Location Parkville Md

18 (a) Funeral director Ulloyd Funeral Home
(b) Address 200 E Orleans St.

19 (a) AUG 31 1946 (Written not later than 48 hrs. after death) (b) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1946, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 29 1946 to Aug. 30 1946, and that I last saw him alive on Aug 30 1946

Immediate cause of death: Resp. failure — Duration

Due to Pulmonary edema

Due to Severe 2nd ° burns.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8/29/46 at 6:30 PM M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home. While at work?
(Specify type of place)
(e) Means of injury Scalding water.

23. Signature John B Zrlla M. D.
Address Date signed 8-30-46

Howard J. Moreno, M. D. X

VS 150

G43334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G43334

Registered No.

TN. 80662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-5-
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 E. 29th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B. Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1st 1880

8. AGE: Years	Months	Days	If less than one day
66	6	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joshua Stevenson
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Haase
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7/1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Hlbert Funeral Home
(b) Address 2008 Orleans St.

19 (a) Filed (b) Registrar

AUG 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30th 1946, at 11.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 30 1946 to Aug. 30 1946 and that I last saw him alive on Aug. 30 1946.

Immediate cause of death Pneumonia abscess, Lt. - ? Thr. — Duration

Due to Hydronephrosis + Hydroureter, Lt. - ? Thr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Faulbe M. D.
Address Balto. City Hosps Date signed 8-30-46

G43335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G43335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 W. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James G. Showacre
3 (b) If veteran, name war Civil
3 (c) Social Security Account No. None

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife GRACE SHOWACRE
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) NOVEMBE 21-1869

8. AGE: Years 76 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Michael S. Showacre
13. Birthplace Md

MOTHER
14. Maiden Name Anna —
15. Birthplace Md

16 (a) Informant Grace Showacre
(b) Address 1232 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof September 2-46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Holt & B. M. Walter
(b) Address Pratt & Stricker Sts

19 (a) AUG 31 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946 at 10 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1946 to Aug 29 1946 and that I last saw him alive on Aug 29 1946.

Immediate cause of death Cardiac Failure — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 3834 Pk. Hts. Ave. Date signed Aug 31, 1946

VS 150

X

Dr. Sevcick
4200 Parkwood

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓107

G43336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 La Salle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 La Salle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Franz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1865

8. AGE: Years	Months	Days	If less than one day
80	11	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Peter Franz
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Baugh
15. Birthplace Germany

16 (a) Informant Mrs. Catherine M. Franz
(b) Address 4403 La Salle Avenue

17 (a) Burial (b) Date thereof 9/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) AUG 31 1946 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1946 to Aug 30 1946, and that I last saw h LIVE alive on Aug 22 1946.

Immediate cause of death: Broncho pneumonia — Duration: 2 days
Due to: Bronchitis, chronic — 5 wks
Due to:
Other Conditions: Poly arthritis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Charles V. Sevcik
Address 4200 Parkwood Ave. Date signed 8/31/46

VS 150

Sevcik ×

G43337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G43337

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 Harview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2/3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Harview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NUNZIATA GEMMA

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-01-3673

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nunzio Gemma

6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1892

8. AGE: Years 53 | Months 11 | Days 5 | If less than one day: hr. min.

9. Birthplace Catania, Sicily
(Town, county, and state)

10. Usual Occupation Bushman

11. Industry or business Cohen & Goldman

FATHER
12. Name Joseph Greco
13. Birthplace Catania, Sicily

MOTHER
14. Maiden Name Antonio Greco
15. Birthplace Catania, Sicily

16 (a) Informant Mr. Nunzio Gemma
(b) Address 3011 Harview Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 31 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1946 at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Aug. 29 1946 and that I last saw her alive on Aug 29, 1946.

Immediate cause of death: Primary Carcinoma, both breasts — Duration 1 yr.
Due to: Generalized carcinomatosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Janney, M. D.
Address 7101 Harford Rd. Date signed 8/29/46

VS 150

Important. Physicians: please write the causes of death clearly and legibly.

G43338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G43338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE & JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County ——
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 E 33rd ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MATILDA KIPP

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: FREDERICK M. KIPP

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 4 JUNE 1870

8. AGE: Years 76 | Months 2 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace: BALTIMORE — MARYLAND
(Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business: HOME

FATHER
12. Name: NOT KNOWN
13. Birthplace: —

MOTHER
14. Maiden Name: NOT KNOWN
15. Birthplace: —

16 (a) Informant: IRVING W. KIPP
(b) Address: 1524 E 33rd ST

17 (a) ENTOMBMENT (Burial, cremation, or removal) (b) Date thereof 9-2-46 (month) (day) (year)
(c) Cemetery or crematory: LORRAINE
Location: BALTIMORE, MD.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 31 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 AUGUST 1946, at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 AUGUST 1946, to 29 AUGUST 1946, and that I last saw h[illegible] alive on 29 AUGUST 1946.

Immediate cause of death	Duration
BRONCHO PNEUMONIA	2 DAYS
Due to CEREBROVASCULAR ACCIDENT	7 DAYS
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	DEC. 6 YRS.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Judd B. Cage, Jr. M. D.
Address: Kernan's Hospital Date signed 8-29-46

VS 1

G43339 Dup BCH 6-3241/2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 106 c

Registered No. G43339

Please write the cause of death clearly and legibly. Correct age is especially important. Physicians: please fill out all items of information should be carefully applied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run and Harford Road.
(c) Hospital or institution: Lydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Cardelia Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Edward King (EDWARD FRANCIS KING)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1945

8. AGE: Years	Months	Days	If less than one day
0	11 mos	19	— hr. — min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Clarence W. King
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary J. Knickman
15. Birthplace Maryland Penna

16 (a) Informant parents
(b) Address above

17 (a) Burial (b) Date thereof 8/31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto.

18 (a) Funeral director Geo. Herman Lemmon
(b) Address 4611 Park Hgts Ave

19 (a) AUG 31 1946 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1946, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1946, to Aug 30 1946, and that I last saw him alive on Aug 30 1946

Immediate cause of death	Duration
Respiratory and cardiac death following	
Due to tracheotomy for laryngo tracheal bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Lydenham Hosp Date signed 8-30-46 M. D.

G43340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G43340 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 20 Yr
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H Kollinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alice D. Dittman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1892

8. AGE: Years 54 | Months | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Ticket Agent

11. Industry or business Greyhound Bus Co.

FATHER
12. Name Michael Kollinger
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Mayers
15. Birthplace Maryland

16 (a) Informant Mrs Alice Kollinger
(b) Address 4108 Edmondson Ave

17 (a) Burial (b) Date thereof Sept 3/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Balto. Md

18 (a) Funeral director Harry A. Sitzler
(b) Address 4104 Edmondson Ave

19 (a) AUG 31 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Aug 1946, at 5 00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William H Helfrich M.D.
Medical Examiner.
Date signed 31 Aug 46

VS 191

G43341

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43341

CERTIFICATE OF DEATH 121B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Earl Court Apts.
(b) Street address St. Paul & Preston Sts.
(c) Hospital or institution:

11

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Paul & Preston Sts.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Nellie M. Berger

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John B. Berger
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------- 1871

8. AGE: Years	Months	Days	If less than one day
75	---	---	-- hr. -- min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ---

FATHER
12. Name William F. Smith
13. Birthplace Massachusetts

MOTHER
14. Maiden Name Catherine Murray
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Stella M. Smith
(b) Address Earl Court Apartments

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaby and Son
(b) Address 805 N. Calvert Street

19 (a) (Date received by registrar) (b) for Williams, M.D. Registrar

VB 284

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1946 to Aug 30 1946 and that I last saw him alive on Aug 30 1946.

Immediate cause of death
(a) Marasmus
Due to chronic glomerular nephritis
Due to
Other Conditions None.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

Duration Interval between onset and death.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randall R. Smith, Jr. M. D.
Address 1014 St Paul St Date signed Aug 44

X

G43342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G43342 Registered No.

Please answer all questions in full. Unknown or information should be carefully supplied. The space is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 St. Johns Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 89 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 St. Johns Road (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country ------

3 (a) FULL NAME John T. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Adelia Clarke
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 27, 1857

8. AGE: Years	Months	Days	If less than one day
89	3	64	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Real Estate Broker
11. Industry or business ------

FATHER
12. Name James Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Not obtainable
15. Birthplace " "

16 (a) Informant James Clarke Murphy
(b) Address 107 St. Johns Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) SEP 1 1946 (Date received) (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Aug. 1946, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1st Apr. 1946 to 31 Aug 1946, and that I last saw him alive on 30 Aug. 1946.

Immediate cause of death Arteriosclerotic cardiovascular disease
Due to Chronic Myocarditis
Due to Acute Myocardial failure.
Due to

Duration
5 Mo ?
24 Hrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr. M. D.
Address 3311 St Paul St Date signed 8/31/46

G43343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G43343
Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 4th
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Alexandria
(If outside city or town limits, write RURAL and give town)
(d) Street No. 68 Yale Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norbert Dvante

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-3-44

8. AGE: Years	Months	Days	If less than one day
2½	4	28	hr. min.

9. Birthplace Missouri
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Norbert Dvante
13. Birthplace Missouri

MOTHER
14. Maiden Name Therese Queen
15. Birthplace Missouri

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvary Cemy
Location St Louis, Mo

18 (a) Funeral director John P Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 31 1946 at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1946 to Aug - 31 1946 and that I last saw him alive on Aug - 31 1946.

Immediate cause of death	Duration
(a) Cardiac failure during operation	
(b) Congenital heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 31 August 46

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard D. Bush M. D.
Address JHH Date signed 31 Aug 46

VS 150

G43344 BALTIMORE CITY HEALTH DEPARTMENT G43344
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 M
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Bassi

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Vergie Bassi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15th 1868

8. AGE: Years 78 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Home Keeper
11. Industry or business Shoemaker

FATHER
12. Name (Unknown) Bassi
13. Birthplace Italy

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Helen Hayes
(b) Address 1725 St. Paul St.

17 (a) Burial (b) Date thereof 9/3/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location Washington D.C.

18 (a) Funeral director William Bok Jose
(b) Address 1217 St. Paul St

19 (a) 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30/46 19 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22/46 to 8/30/46 and that I last saw h[illegible] alive on 8/30/46 19

Immediate cause of death: Cardiorespiratory failure — Duration
Due to Myocardial degeneration
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Wells M.D.
Address 1 E Pleasant St Date signed 8-30-46

Olga H. Kamsler, M.D. X

VS 150

Please answer all questions as completely as information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G43345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43345 Registered No.

Please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The [illegible] is especially important. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Spaulding Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Spaulding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Mandel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Late Lottie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Morris Mandel
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs Ada Whitten
(b) Address 3602 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

(a) SEP 1 1946 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1946 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1941 to Aug. 31, 1946 and that I last saw him alive on Aug 31, 1946

Immediate cause of death
Coronary Heart Disease
Coronary Thrombosis — Duration 5 years 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd Date signed Aug 31/46

Huntington Williams, M.D. Registrar

G43346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43346 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3341 Beech Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3341 Beech Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert L. Sunderland.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel B Sunderland
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept 5 1885

8. AGE: Years	Months	Days	If less than one day
60	11	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired machinist
11. Industry or business

FATHER
12. Name John Sunderland.
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Geyer
15. Birthplace Md.

16 (a) Informant Ethel B Sunderland
(b) Address 3341 Beech Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Schenawolf & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 1 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 August 1946, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Aug 1946, to 31 Aug 1946, and that I last saw him alive on 31 Aug 1946.

Immediate cause of death: Coronary Thrombosis — Duration 12 hrs

Due to Cardio Vascular - Renal Disease — 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Lt. Frederick Johnston Jr. M.D.
Address 11 E Chase St Date signed 31 Aug 46

VS 150

G43347 ✓ G43347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1227 N. Patterson Park ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 or 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 N. Patterson Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E. Hildebrand

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband ~~or wife~~ Charles Hildebrand

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11, 1877

8. AGE: Years 69 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name
13. Birthplace Anna Maria Magdalene Cristnacht Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Norma L. Hildebrand
(b) Address 1227 N. Patterson Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette ave

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1946, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 29 1946 and that I last saw h.e. alive on Aug 29 1946.

Immediate cause of death
Coronary Thrombosis
Chronic cholecystitis

Duration
2 mos.
3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Lippy M. D.

Address 1321 N. Patterson Pk Ave Date signed 8/31/46

X

Typed or filled in with ink. Every item of information should be carefully supplied. The space for "Age" is especially important. Physicians: please write the causes of death clearly and legibly.

643348 104067

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X V 14

643348 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore Annapolis, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2 Box 542 St Margaret (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Linda Cromwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11th 1940

8. AGE: Years 6 | Months 4 | Days 20 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Julius Allen
13. Birthplace Maryland

MOTHER
14. Maiden Name Rose Cromwell
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory St Margarets
Location St Margarets Md

18 (a) Funeral director J. B. Johnson
(b) Address Glen Burnie, Md.

19 (a) 9/3/46 (Date rec'd by reg'r) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31st 1946 at 12.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Aug 1946 to 31 Aug 1946 and that I last saw h[illegible] alive on 31 Aug 1946.

Immediate cause of death Respiratory failure — Duration

Due to Flu Meningitis — 1 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson E. Hughes
Address Balt. City Hosp Date signed M. D.

G43349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G43349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4004 Kathland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Kathland Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lena Kohlenberg Parrish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife S. R. Parrish

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1875

8. AGE: Years 71 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Frederick Co., Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name George F. Kohlenberg
13. Birthplace Frederick Co., Maryland

MOTHER
14. Maiden Name Laura Beck
15. Birthplace Frederick Co., Maryland

16 (a) Informant Mr. S. R. Wallis Parrish
(b) Address 4004 Kathland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Vernon
Location White Hall, Maryland

18 (a) Funeral director Howard S. Franklin
(b) Address 4004 Kathland Ave.

19 (a) 9/4/46 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1946, at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944, to Aug 31 1946, and that I last saw h[illegible] alive on Aug 31 1946.

Immediate cause of death Carcinoma of Colon — Duration 2½ years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of Colon
Colostomy done Feby. 1944
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert F. Hellmann M.D.
Address 6 E Biddle St Date signed 9/1/46 M. D.

G43[illegible] B 43350 BALTIMORE CITY HEALTH DEPARTMENT 94a G43350
Registered No. B 43350

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Oakley Ave. -15 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Riga, Russia (Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER 12. Name Mayer Berman
13. Birthplace Russia

MOTHER 14. Maiden Name
15. Birthplace Russia

16 (a) Informant Ceal Kessler
(b) Address 1439 Penna. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-46 (month) (day) (year)
(c) Cemetery or crematory Brai Israel
Location Southern Ave

18 (a) Funeral director Jacob Levine Jno
(b) Address 1439 E. Balto. St

19 (a) 9-2-1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1st 1946 at 12.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1946 to Sept 1 1946, and that I last saw h[illegible] alive on Sept 1 1946.

Immediate cause of death: Acute Pulmonary Edema — Duration

Due to Coronary Occlusion (Antero myocardial infarction)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Bauer M. D.
Address Univ. Hospital Date signed 9-1-46

Please type or print plainly. Every item of information should be carefully supplied. This space is especially important. Physicians: please write the causes of death clearly and legibly.

G43357 BALTIMORE CITY HEALTH DEPARTMENT G43357
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MANAS WALDORF
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W
6 (b) Name of husband or wife Amelia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870
8. AGE: Years 76 | Months | Days | If less than one day hr. min.
9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Mfg. Agent
11. Industry or business

FATHER
12. Name Moses
13. Birthplace Germany

MOTHER
14. Maiden Name Florence
15. Birthplace Germany

16 (a) Informant Sigmund K. Waldorf
(b) Address 2701 Eulton Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-46 (month) (day) (year)
(c) Cemetery or crematory Ohab Shalom
Location Owned St.
18 (a) Funeral director Jack Levin Inc
(b) Address 1103 Eutaw Place
19 (a) SEP 3 1946 (Date rec'd by registrar) (b) Herrington Williams (Registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH 9-1 1946, at 5:50 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1946 to 9-1 1946 and that I last saw him alive on 9-1 1946.
Immediate cause of death Cerebral Vascular Accident — Duration
Due to Hypertensive Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Nathan B. Hyman M. D.
Address Sinai Hospital Date signed 9-1-46

VS 150

Please answer all questions as especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G43352 BALTIMORE CITY HEALTH DEPARTMENT G43352
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 S Kenwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Krygier
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Maryanna Krygier
6 (c) If give, give age years
7. Birth date of deceased (mo., day, yr.) 1870
8. AGE: Years 76 Months Days If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Ethel Ermer
(b) Address 902 S. Kenwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave
18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.
19 (a) EP 2 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1946 at 1.20 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 7th 9 1946. to Aug 17th 1946 and that I last saw h alive on 8/17th 1946.
Immediate cause of death Cardiac Dilatation — Duration one month
Due to Chronic myocarditis — 1 yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A J Faulkner M. D.
Address 100 N - Milton Date signed 9/3/46

Please write clearly with pen and ink. Use no abbreviations. If unknown, state so. Do not leave any blanks. The information should be carefully supplied. The space for "Cause of Death" is especially important. Physicians: please write the causes of death clearly and legibly.

G43,559
CMK-104155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 G43,548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
63- 8- 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 Elliott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Weever

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10-1882

8. AGE: Years	Months	Days	If less than one day
63	8	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lou Weever
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 9/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cemetery
Location O'Donnell St.

18 (a) Funeral director John J. Duda
(b) Address 2429 Hudson St.

19 (a) SEP 2 1946 (Huntington Williams) registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 31 1946, at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1946, to Aug. 31 1946, and that I last saw him alive on Aug. 31 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Tuberculosis?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Marlborough M. D.
Address Balto City Hosp. Date signed 8-31-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G43354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G43354 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brendale (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 62 Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Opal G. Robinson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-89

8. AGE: Years	Months	Days	If less than one day
56	8	2	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name	Lloyd D. Robinson
13. Birthplace	Va.
MOTHER 14. Maiden Name	Prudence Grant
15. Birthplace	Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory
Location Philippi W. Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Washington & North & Pa. Aves.
SEP 2 1946 (Date filed by Registrar) (b) Washington Williamson, W. Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 8-31 1946 and that I last saw h alive on 8-31 1946

Immediate cause of death: Cerebral edema — Duration: 1 wk
Due to: Hypertension, essential — unknown
Due to
Other Conditions: Cardiac decompensation — 4 wks
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 31 Aug 46

VS-150

X

G43355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43a

G43355 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: 30 Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
Street No. 2715 Northern Pkw (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes T Dilly

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/28/1870

8. AGE: Years 76 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Gibson
13. Birthplace Scotland

MOTHER
14. Maiden Name Sarah Smith
15. Birthplace Scotland

16 (a) Informant Mrs. Mary Diffendal
(b) Address 2715 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1946 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1946 to 8-31 1946 and that I last saw he alive on 8-31 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.

Address 1211 Light St. Date signed 8-31-46

VS 150

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

G43356 **CERTIFICATE OF DEATH** 94a Registered No. G43356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5501 Fair Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5501 Fair Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert G. Codd

3 (b) If veteran, name war: World War #1 & #2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ann J. Codd (nee Yeager)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1898

8. AGE: Years 48 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Washington Navy Yard

FATHER
12. Name: Stephen T. Codd
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Emma J. Kirby
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Ann J. Codd
(b) Address: 5501 Fair Oak Ave. Balto. 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

SEP 2 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 August 1946, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D.
Medical Examiner.
Date signed 31 Aug. 1946

VS 151

G43357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G43357 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 Arunah Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUST J. BAUERNSCHMIDT

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-10-8109

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Pauline La Porte Bauernschmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1874

8. AGE: Years	Months	Days	If less than one day
72	6	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Balto. Country Club

FATHER
12. Name John Bauernschmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Marr
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Sherman
(b) Address Chesapeake City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Aug. 29, 1946, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 26 1946 to August 29 1946, and that I last saw him alive on August 29 1946

Immediate cause of death: Acute Myocardial Failure — Duration: 4 days

Due to Coronary Thrombosis

Due to

Other Conditions Pneumonia — Colapse

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.

Address 24 N. Fulton Ave Date signed 8/31/46

VS 130

X

G43358 | BALTIMORE CITY HEALTH DEPARTMENT | G43358
CERTIFICATE OF DEATH
51B | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Old Home Rd. (If rural give location) Overlea
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H MooRE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Blanche A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-1864

8. AGE: Years	Months	Days	If less than one day
81	8	6	hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business

FATHER
12. Name William Moore
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amanda Pettit
15. Birthplace York, Pa.

16 (a) Informant Mrs. FrederickStegman
(b) Address 112 Homeland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/46 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) 1946 (Date rec'd by registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1946 at 11½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 8-31 1946 and that I last saw h(M)alive on 8-31 1946

Immediate cause of death Anemia — Duration
Due to Carcinoma of Prostate
Due to
Other Conditions Carcinoma Rt Testicle
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Foster Sykes M. D.
Address So Balto Gen Hosp Date signed 8/31/46

VS 150

Please write the causes of death clearly and legibly. Physicians: please ... information should be carefully supplied. The ... is especially important.

G43359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G43359 Registered No.

499892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E Ellis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-24

8. AGE: Years	Months	Days	If less than one day
21	10	25	24 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Office Worker
11. Industry or business Standard Gas

FATHER
12. Name Edward G. Ellis
13. Birthplace md.

MOTHER
14. Maiden Name Anna Clark
15. Birthplace md.

16 (a) Informant: Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3rd 46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

(a) Date received SEP 2 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 30 1946 at 8.50 AM P

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 29 1946 to Aug - 30 1946 and that I last saw h[illegible] alive on Aug - 30 1946.

Immediate cause of death: Cardiac failure — Duration: 2 hrs
Due to: Anoxia
Due to: Pneumonia, lobar, due to Hemophilus influenza I w/b
Other Conditions: Mycotic Uremia grade 3 plus. Cavity of cerebellation due to infection
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Primordial Splenosis Left Ovary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 8/31/46

VS 150

Every item of information should be carefully supplied. The age is especially important. Physicians; please write the causes of death clearly and legibly.

G43560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 46F

G43560

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Della Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. E Howard Robinson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ella V. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-1897

8. AGE: Years	Months	Days	If less than one day
49	7	23	hr. min.

9. Birthplace Della Balto Co. Md (Town, county, and state)
10. Usual Occupation Checker + Watchman
11. Industry or business

FATHER
12. Name Thomas Robinson
13. Birthplace Md

MOTHER
14. Maiden Name Martha Robinson
15. Birthplace Md.

16 (a) Informant Ella V. Robinson
(b) Address Della Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3 46 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Howard Co.

18 (a) Funeral director F. C. Higinbothom
(b) Address Ellicott City Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1946 at 2.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15, 1946 to Aug 31 1946, and that I last saw h alive on 8-31 1946.

Immediate cause of death: Wounds and accidents chest
Due to Cirrhosis of liver
Due to Tumor (sub malignant) of liver
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Cirrhosis of liver, Liver tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R E Bauer M.D. M. D.
Address Univ. Hospital Date signed 8-31-46

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G43361 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1652 N. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1652 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE MALLOW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Zelek Liberman
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Louis Mallow
(b) Address 1652 N. Bentalou St.

17 (a) Burial (b) Date thereof Sept 2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Har Zion Cong Cemt.
Location Hamilton Ave, Rosedale

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W. North ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1946, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1946, to 9-1 1946, and that I last saw her alive on 8-16 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 5 weeks
Due to Arteriosclerosis
Due to Hypertensive cardio-vascular disease
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton J. Wilder M. D.
Address 1719 EUTAW PLACE Date signed 9-2-46

VS 150

X

correct age is especially important. Physicians: please write the
every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT

G43362 CERTIFICATE OF DEATH 937 Registered No. G43362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 East Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 East Baltimore St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ISAAC ROLL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Plumber

FATHER
12. Name Benjamin Roll
13. Birthplace Russia

MOTHER
14. Maiden Name Rose ?
15. Birthplace Russia

16 (a) Informant Benjamin Roll
(b) Address 4213 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton Ave.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1126 W. North Ave.

19 (a) 9/1/46 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1946, at 9:45 PM

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

	Duration
Immediate cause of death: Arteriosclerotic Cardio Vascular Disease	3 yrs.
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. N. Kamman, Jr. M.D. Medical Examiner.
Date signed 2 Sept 1946

VS 6

G43363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G43363

G43363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 S. BENTALOU ST.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 S. Bentalou Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH NELSON PEREGOY, SR.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: FANNIE Elizabeth Peregoy

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1875

8. AGE: Years 70 | Months 8 | Days 25 | If less than one day — hr. — min.

9. Birthplace: BALTIMORE, MD (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: —

FATHER
12. Name: Joseph Janes
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Theresa BEARMAN
15. Birthplace: Baltimore, Md

16 (a) Informant: Wife
(b) Address: 522 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 Sept. 46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Maryland

18 (a) Funeral director: A. B. Thibideau & Son
(b) Address: 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1946, at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1946, to Sept. 1 1946, and that I last saw him alive on Sept. 1 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 24 Hours

Due to: Hypertension

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature: Alfred Cole M. D.
Address: 1934 WILKENS AVE. Date signed: Sept. 1946

VS 150

G43364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOH
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town, give also RFD number and name of town)
(d) Street No. 410 S. Bethel Pk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Andrzejewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Wladyslaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1838

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Frank Kalinowski

13. Birthplace Poland

MOTHER 14. Maiden Name Wozniski

15. Birthplace Poland

16 (a) Informant J. Andrzejewski

(b) Address 410 S Peterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W Ozarzewski

(b) Address 1900 Eastern Ave

19 (a) 9/4/46 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Aug 1946 at 10:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Hypertension & Arteriosclerotic Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm J Klyhiak M.D. Medical Examiner

Date signed Aug 31-1946

VS 151

G43365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G43365

1. PLACE OF DEATH:
(a)-Baltimore City, Maryland
(b) Street address 2013 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 E. Fairmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Coplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie
15. Birthplace Russia

16 (a) Informant Sidney Coplan
(b) Address 2013 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd + Hamilton Ave

18 (a) Funeral director Jacks Lewis Inc.
(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-46 19 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1946 to Aug 30 1946 and that I last saw him alive on Aug 30 1946

Immediate cause of death Hemorrhage into Cerebrum — Duration 3 Days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon

Address 129 S Broadway Date signed 8/30/46 M.D.

VS 150

G43366

CWK-102359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G43366 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 5d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steven Milwais or Meluais

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-2735

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16-1880

8. AGE: Years	Months	Days	If less than one day
65	8	15	hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jim
13. Birthplace Greece

MOTHER
14. Maiden Name Drene
15. Birthplace Greece

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Baltimore Md
18 (a) Funeral director Durward D Covington
(b) Address 21 W. 25th St.
19 SEP 2 - 1946 (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1946 at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1946 to Aug. 31 1946, and that I last saw him alive on Aug. 31 1946.

Immediate cause of death: Bronchopneumonia — Duration 2 Days
Due to Carcinoma Bladder — ?
Both ureters transplanted
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: CA Bladder ; metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Elmer Beacham
Address Balto City Hosp Date signed 31 Aug 46 M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The use of BLACK INK.

CHK-102733 G43367

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43367 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 22-
(e) Length of stay in Baltimore (yrs., mos., or days) 43- 10- 12-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Linden Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Owen Costello

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-14-4496

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19-1902

8. AGE: Years 43 | Months 10 | Days 12 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation PLUMBERS HELPER

11. Industry or business

FATHER
12. Name William F. Costello
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Patterson
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitles
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/3/46 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Cragg Sons
(b) 118 W. Mt. Royal Ave

19 (a) 9/3/46 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1946, at 5:02 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1946 to Aug. 31 1946, and that I last saw h 1E alive on Aug. 31 1946.

Immediate cause of death
Pulmonary tuberculosis, far advanced
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Marcey E. Jacobson M. D.
Address City Hospitals Date signed 8/31/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43568 (Registered No.)

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2532 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Besse Rose

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 7 1871

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Woman
11. Industry or business

FATHER
12. Name Sol
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Mrs. Dorothy
(b) Address 2532 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-46 (month) (day) (year)
(c) Cemetery or Crematory Pikesville
Location Pikesville Rd & Hemaltyn Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/46 19 , at 6 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5th 19 46 to Sept 2nd 19 46 and that I last saw h alive on Aug 25th 19 46

Immediate cause of death	Duration
Arteriosclerotic coronary disease	few years
Due to Coronary thrombosis	few years
Due to	1 hour
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature aa Wenstock
Address 4603 Kirkstan Date signed 9/5/46 M.D.

G43569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument - Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give township)
(d) Street No. 2307 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Zyk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 71 Months Days If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Dolowyw Weslowy
13. Birthplace Poland

MOTHER 14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mary Zyk
(b) Address 2307 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-46 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem
Location Washington Boulevard

18 (a) Funeral director Jake Lewis Inc
(b) Address 1316 E Balto St

19 (a) 9/3/46 (Date filed by registrar) (b) Register's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1946 at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1946 to 8-31 1946 and that I last saw him alive on 8-31 1946

Immediate cause of death cerebro - vascular accident — Duration

Due to Hypertension & arteriosclerotic heart disease

Due to

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliott J. Wachman M.D.
Address Sinai Hospital Date signed 8-31-1946 M. D.

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43370 — BALTIMORE CITY HEALTH DEPARTMENT — G43370 Registered No.

CERTIFICATE OF DEATH 1937

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Bischoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife C. Henry Bischoff
6 (c) If alive, give age 8. years

7. Birth date of deceased (mo., day, yr.) 19 Sept. 1859

8. AGE: Years	Months	Days	If less than one day
86	11	10	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Charles Holzerman
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Goebel
15. Birthplace Germany

16 (a) Informant: August H. Bischoff
(b) Address Elkton - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 Sept. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Baltimore - Md.

18 (a) Funeral director C. B. Tippett & Son
(b) Address 1300 Eutaw Place, Balto, Md.

19 (a) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 August 19 46, at 10:27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1946 to 8-29 1946 and that I last saw her alive on 8-29 1946.

Immediate cause of death: Arteriosclerotic Heart Disease
Bronchopneumonia — Duration: 1 mos. 6 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Coleman M.D. M. D.
Address 1201 Poplar Grove St. Date signed 9/3/46

VS 150

G43371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G43371 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1559 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Mark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August - 5 - 1936

8. AGE: Years	Months	Days	If less than one day
10		26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John C. Mark Sr

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Louise Schellenberger

15. Birthplace Baltimore Md.

16 (a) Informant John C. Mark Sr

(b) Address 1559 N. Milton Ave

17 (a) Burial (b) Date thereof 9 - 3 - 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Pulaski Ave.

18 (a) Funeral director John C. Mallay Inc

(b) Address 2435 [illegible]

19 (a) (b)
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1946, at 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/29/46 about 3 P.M. 8/2
(b) Where did injury occur Water hole in cemetery
(c) Did injury occur at home, on farm, industrial place, in public place? Balto Cemetery while at work? No
(d) Means of injury accidental drowning

23. Signature C. J. Fabricante M.D.
Medical Examiner.
Date signed 9/1/46

G13372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 47372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Lombardy Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Russell Davis
3 (b) If veteran, name war
3 (c) Social Security Account No. 235-05-85[illegible]
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Susie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-22-02
8. AGE: Years 43 Months 11 Days 9 If less than one day hr. min.
9. Birthplace W Va (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business
FATHER 12. Name John Davis
13. Birthplace W Va.
MOTHER 14. Maiden Name Edna Bennett
15. Birthplace W. Va.
16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 2 46 (month) (day) (year)
(c) Cemetery or crematory
Location East Rairgell Md Va
18 (a) Funeral director James J Brugemyer
(b) Address 1407 Eastern Ave Rd
19 (a) 9/3/46 (Date rec'd by registrar) Huntington Williams Mill (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1946 10:30 a.m.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1946 to Aug 31 1946 and that I last saw him alive on Aug 31 1946.

	Duration
Immediate cause of death: Coronary occlusion	
Due to	
Due to	
Other Conditions: Carcinoma of lung (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip D. Wagley M. D.
Address Johns Hopkins Hosp Date signed 8-31-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G43373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43373
Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 N. Marlyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Inez B. Rowland

3 (b) If veteran, name war NO
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband George E. Rowland Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15th 1889

8. AGE: Years	Months	Days	If less than one day
57	6	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Joseph Murty
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Arnold
15. Birthplace Balto. Md.

16 (a) Informant Geo. E. Rowland Sr
(b) Address 324 N. Marlyn Ave - Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 E. Paul St.

SEP 2 1946 Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1946 at 130 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Aug 1946 to 1 Sept 1946 and that I last saw h alive on 1 Sept 1946

Immediate cause of death Cardio Resp. Failure — Duration

Due to Chr. Edema & Hydro Thorax, Bilateral

Due to Hypertensive Arteriosclerotic Cardio Vascular Renal Dis.

Other Conditions Terminal Hemi Nt Temp. parietal Encephalomy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter G Stall Jr. M. D.
Address Post Balto Gen Hosp Date signed 9/1/46

VS 150

Chiveral

G43374

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 51B

G43374 Registered No.

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2319 E Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2319 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Chiveral

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct 22 1877
8. AGE: Years 68 | Months 6 | Days 9 | If less than one day: hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Supt
11. Industry or business: C. Heller Co

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden Name: Sarah Unknown
15. Birthplace: Maryland

16 (a) Informant: John Porter
(b) Address: 3301 Elmley Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/4/46 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore Md
18 (a) Funeral director: Wilson & Pace
(b) Address: 1219 E Fayette St
19 SEP 3 1946 Date rec'd by registrar: Wilson H. Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 1946 at 0 29 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1946 to Sept 1 1946 and that I last saw h IM alive on Aug 31 1946.

Immediate cause of death — Duration
(a) Arteriosclerosis - unclassified
Cardio - Vascular disease — 2
Due to Hypertension — 7
Due to
Other Conditions Ca - prostate
(Include pregnancy within 3 months of death)
Date of operation March 1946
Major findings of operation: Carcinoma prostate
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Louis F. Kleinau M.D.
Address 2623 E. Monument Date signed 9/2/46

VS 150

G43375

DRUERY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43375 Registered No.

Please answer every item or information should be carefully supplied. The question as to age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 E Federal Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 E Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilford Druery

3 (b) If veteran, name war: no
(c) Social Security Account No.: none

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If married, widowed, or divorced, give age years

7. Birth date of deceased (mo., day, yr.): Jan 6, 1873

8. AGE: Years 73 | Months 7 8 | Days 27 5 | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Teamster

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Md

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Md

16 (a) Informant: Mrs Virginia Ingram
(b) Address: 2108 E Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-46 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Eastern Ave

18 (a) Funeral director: Albert L. Hilt Jr
(b) Address: 1606 N Chester Street

19 (Registrar's signature): SEP 3 1946 (Date received) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31 1946 at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Aug 31 1946 and that I last saw deceased alive on Aug 30 h 46

Immediate cause of death: Acute Cardiac Failure — Duration: 1 day

Due to: Arteriosclerotic Heart Disease — Duration: 10 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Israel Rosen M. D.
Address: 2413 E Monument St Date signed: 8/31/46

G43576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

G43576 Registered No.

The items of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 E. 32nd Street
(c) Hospital or institution: 9 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 E. 32nd. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA MAY CATRUP

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1874

8. AGE: Years 72 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Saleslady
11. Industry or business Retired

FATHER
12. Name William Catrup
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Eliza Jones
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Ralph F. Truitt
(b) Address 1609 E. 32nd. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
SEP 3 1946 Huntington Woodlawn, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/43 19 to 8/31/46 19; and that I last saw h[illegible] alive on 8/31/46

Immediate cause of death: Carcinoma of Breast — Duration: 1 yr. 2 mos.
Due to
Due to
Other Conditions: Suspended Respiration — 3 mo.
(Include pregnancy within 3 months of death)
Date of operation 7/1/46
Major findings of operation: Brain Carcinoma
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature B. H. Harryman M. D.
Address 1710 E. 33rd St. Date signed 9/3/46

G83577 BG# B54131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √159

G83577

Registrar's No.

Typewriter or information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Woodward Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-46

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Walter Burns
13. Birthplace Md

MOTHER 14. Maiden Name Irene Lackey
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo AUG 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 3 1946 (Date Rec'd by Registrar) Hunter Jon Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1946 to Aug 26 1946 and that I last saw him alive on Aug. 26 1946

Immediate cause of death Peritonitis — Duration 4 days
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gilbert J. Sheldon M.D.
Address Date signed 8/26

VS 150

G43578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43578 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Smallwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 N. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Ryan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: Robt. E. Ryan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1890

8. AGE: Years	Months	Days	If less than one day
56	-	30	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name August Haupt
13. Birthplace Germany

MOTHER
14. Maiden Name Katharine Stedtnitzer
15. Birthplace Germany

16 (a) Informant Mr. Robt. E. Ryan
(b) Address 100 N. Smallwood St

17 (a) Burial (b) Date thereof 9/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Volz
(b) Address 1300 W. Lombard St

19 (a) SEP 3 - 1946 H. Livingston Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1946, at 11:25 PM
21. I certify that death occurred on the date above stated; that I attended deceased from July 1937 to Aug 31 1946
and that I last saw alive on Aug 31 1946

Immediate cause of death	Duration
(a) Chronic Cardiac Decompensation	4 Yrs
Due to (b) Chronic Myocarditis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Grant W. Lahm M.D.
Address 1735 Eye St Date signed 9/2/46

VS 150

G43379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G43379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 W Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 W. Fayette St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lida Grimes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frederick N. Grimes

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1872

8. AGE: Years 73 | Months 11 | Days 17 | If less than one day hr. min. 16

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

MOTHER / FATHER

12. Name William Brower

13. Birthplace Baltimore, Md.

14. Maiden Name Unknown

15. Birthplace Baltimore, Md.

16 (a) Informant Frederick N. Grimes

(b) Address 763 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1946 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director Frederick P. Cole

(b) Address 1700 N. Lombard St

19 (a) SEP 3 1946 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2, 1946 at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1946 to Aug 1946.
and that I last saw h alive on 1946

Immediate cause of death Carcinoma left breast — Duration 1 year

Due to

Due to

Other Conditions Generalized metastasis of Carcinoma (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr

1227 Wash Blvd Date signed Sept 2, 1946 M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G43380

Every item of information should be carefully supplied. The contact #6 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1907 Gwynn Falls Pkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Cramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1908

8. AGE: Years: 38 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: William Podolsky
13. Birthplace: Russia

MOTHER
14. Maiden Name: Roze
15. Birthplace: Russia

16 (a) Informant: Harry Cramer
(b) Address: 1907 Gwynn Falls Pkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-3-46 (month) (day) (year)

(c) Cemetery or crematory
Location: Nebraska Friendship Park

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1429 E Balto St

19 (a) [illegible] (b) [illegible] (Registrar)

SEP 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1946, at 4:28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1946 to 9-2 1946 and that I last saw he alive on 9-2 1946

Immediate cause of death: Intestinal obstruction — Duration

Due to: Bile Peritonitis

Due to: Choledochostenosis

Other Conditions: Biliary Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation: 8-30-46

Major findings of operation: Intestinal Obstruction - Free Bile

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Cipsie R. Friedman

Address: Sinai Hospital Date signed: 9-2-46

G43581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1310

G43581 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 Edmonson Ave,.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md,. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Edmonson Ave,.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE HOLTON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	COLORED	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 25, 1902

8. AGE: Years	Months	Days	If less than one day
44	6	6	hr. min.

9. Birthplace Hartford Co,. Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name John W. Johnson
13. Birthplace Maryland

MOTHER 14. Maiden Name Hannah Preston
15. Birthplace Maryland

16 (a) Informant Mrs. Hannah Johnson
(b) Address 818 Edmonson Ave,.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-46 (month) (day) (year)
(c) Cemetery or crematory Clarks Chapel
Location Hartford Co, Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna,. Ave

19 (a) (Signature and title) Registrar

SEP 3 1946

Huntington Nilliams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1946

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1946 to Aug 31 1946, and that I last saw h[illegible] alive on Aug 31 1946.

Immediate cause of death: Uremia — Duration

Due to: Nephritis

Due to: Essential Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G H Bangert M.D.
Address 722 N. Fulton Ave Date signed 9/2/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The use of INK, TYPEWRITER, or PENCIL is required. DO NOT USE LEAD PENCIL. DO NOT WRITE OVER PRINTED WORDS.

G43382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G43382 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTING WITH PENCIL UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Lyndhurst Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Lyndhurst Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Broomell Hull

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife James Dixon Hull
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) June 29, 1872

8. AGE: Years	Months	Days	If less than one day
74	2	2	hr. min.

9. Birthplace Chester County, Pa.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Seneca Parry Broomell
13. Birthplace Pa.

MOTHER
14. Maiden Name Hannah Ann Passmore
15. Birthplace Pa.

16 (a) Informant Mrs. Ruth P. H. Swartz
(b) Address 728 N. Atherton St., State College, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/46 (month) (day) (year)
(c) Cemetery or crematory Friends Burial Ground
Location Harford Ave. near 25th St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

SEP 3 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1946, at 11 7/10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Coronary thrombosis	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Fried M. D.
Address #316 Medical Arts Bldg Date signed Sept 2/46

Howard J. Lawrence, M.D. X

643383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

643383 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 N Pulaski
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N Pulaski (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Edith H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Christopher E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13 1873

8. AGE: Years 73 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Hayden
13. Birthplace Md

MOTHER
14. Maiden Name Martha Fredericks
15. Birthplace Md

16 (a) Informant Christopher E. Smith
(b) Address 511 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Bays Md

18 (a) Funeral director George A Tighe
(b) Address Fulton Ave & Fayette

19 (a) SEP 3 - 1946 (Date received by local registrar) (b) Registration No. 1346

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Sept. 1946, 2.30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 1 Sept. 46

93

C23384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓469

Registered No. C23384

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPEWRITING, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital 13 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 W. 34th St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ruth Ann Utz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Wh	Wid

6 (b) Name of husband or wife John E. Utz
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1878

8. AGE: Years	Months	Days	If less than one day
67	11	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name George Simpson
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Cleek
15. Birthplace Virginia

16 (a) Informant SARAH E. MATHIAS
(b) Address 608 W 34th ST.

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof Sept 5/46. (month) (day) (year)
(c) Cemetery or crematory Bulgaw, Va
Location

18 (a) Funeral director Thomas F. Donovan
(b) Address 3615-17 Chestnut Ave.
(c) Date received by registrar SEP 3 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946, at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1946 to 9-2 1946, and that I last saw her alive on 9-2 1946.

Immediate cause of death: Gen Carcinomatosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8-31-46
Major findings of operations: Gen carcinomatosis of abdomen
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. L. Carsen M.D.
Address DN. Hospital Date signed 9-5-46

VS 150

G43385 — BALTIMORE CITY HEALTH DEPARTMENT — G43385

CERTIFICATE OF DEATH ✓ 12/a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2333 Brantley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva M. Charles

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: James L. Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1876

8. AGE: Years 69 | Months 10 | Days 5 | If less than one day: hr. min.

9. Birthplace Balto., Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hacker
13. Birthplace Springfield, Ohio

MOTHER
14. Maiden Name Sarah Boone
15. Birthplace Md.

16 (a) Informant Mrs. Sarah Goodhand
(b) Address 2829 Gwynn Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director [redacted] J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) SEP 3 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1946, at 3.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 1 1946, and that I last saw her alive on Sept 1 1946.

Immediate cause of death: cardiovascular collapse — Duration:
Due to: Hypertension - cardiovascular renal disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: coronary infarct

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. N. Worthington M.D.
Address Bon Secours Hosp Date signed 9/1/46 M. D.

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43386 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THERESA M. RATHMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George E. Rathman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Heilmann
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. C. W. Rathman
(b) Address 2135 Southland Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1946, at 6:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1946 to 9/1 1946 and that I last saw her alive on 9/1 1946

Immediate cause of death	Duration
Hypocardial insufficiency	
Due to Hypocardial infarct	
Due to coronary occlusion (post.)	
Other Conditions Pulm. edema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Heinz Rathmann
Address Sinai Hospital Date signed 9/1/46 M. D.

VS 150

G43587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 55E

Registered No. G43587

Every item of information should be carefully supplied. The current age is especially important. Physicians: please write the causes of death clearly and legibly. TYPEWRITE OR PRINT IN INDELIBLE INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 N. University Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. University Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Carl Nolting Tilstort

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frances F. Tilstort
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.): April 26-1878
8. AGE: Years 68 Months 4 Days 6 If less than one day hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired > 30 years
11. Industry or business

FATHER
12. Name: Carl Tilstort
13. Birthplace: Germany

MOTHER
14. Maiden Name: Emma Nolting
15. Birthplace: Maryland

16 (a) Informant: Mrs. Frances F. Tilstort
(b) Address: 106 N. University Parkway

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof: Sept 4-1946 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore Co. Md.

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3231 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2- 1946 at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to 9/2 1946 and that I last saw h alive on 8/31 1946.

Immediate cause of death: Cerebral Thrombosis — Duration 15 min

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Clarkeff Date signed 9/3/46 M. D.

VS 150

G43388 BALTIMORE CITY HEALTH DEPARTMENT G43388

CERTIFICATE OF DEATH √X 46 F

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd
(c) Hospital or institution: Beech Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Edward Harris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret Ann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3rd 1861

8. AGE: Years	Months	Days	If less than one day
85	2	29	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Shoemaker

FATHER
12. Name John Harris
13. Birthplace England

MOTHER
14. Maiden Name Matilda Maris
15. Birthplace England

16 (a) Informant Elsie H. Frederick
(b) Address Ruxton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) (Date rec'd by registrar) SEP 3 1946 (Signature of registrar) Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1946, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Sept 2 1946 and that I last saw him alive on Aug 31 1946

Immediate cause of death: Tumor of Liver type undetermined. — Duration 1 year

Due to:

Due to:

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. Signature A. S. Charlton M. D.
Address 6710 York Rd Date signed Sept 2 1946

over

sypa

G43589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43589 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6204 Pinehurst Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6204 Pinehurst Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Messersmith Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jennie Robinson Messersmith
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) April 26, 1867

8. AGE: Years	Months	Days	If less than one day
79	4	5	hr. min.

9. Birthplace Baltimore Maryland
(Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jacob Messersmith
13. Birthplace Essen Germany

MOTHER
14. Maiden Name Maria Klenglebefel
15. Birthplace Essen Germany

16 (c) Informant Jennie R. Messersmith
(b) Address 6204 Pinehurst Rd

17 (a) Burial (b) Date thereof Sept 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wm Cook Inc
(b) Address 5 E Saratoga St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1946, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939, to 1946, and that I last saw him alive on Aug 15 1946.

Immediate cause of death	Duration
(a) Acute Cardiac Failure	
Due to (b) Chronic Myocarditis	
Due to (c) Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Myron E. Lee M.D.
Address 25 Abraham Hopf. Date signed 9/1/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

G43390 Registered No.

Every item of information should be carefully supplied. Type, with UNFADING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 443 Rosebank Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles L. Dilworth

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	widower

6 (b) Name of husband or wife Emma Agier Dilworth 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10 - 1873

8. AGE: Years	Months	Days	If less than one day
73	10	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Wm Dilworth
13. Birthplace Md

MOTHER 14. Maiden Name Susan R.
15. Birthplace Md

16 (a) Informant Mr. R. B. Jones
(b) Address Sykesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & Oliver Sts

18 (a) Funeral director Harry A. Diffenderffer
(b) Address 410 Edmondson Ave

19 (a) SEP 3 - 1946 (b) Williams, Md Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1st 1946, at 10:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8.26.46 19 to 9.1.46 19 and that I last saw h alive on 9.1.46 19

Immediate cause of death	Duration
pulmonary embolus (right)	
Due to fractured left femur	
Due to	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Aug 26 1946 at 8 P.M
(c) Where did injury occur? Balto. (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury fall ~~down~~ stairs

23. Signature John P. Nogueira
Address Md Gen Hospital Date signed 9/6/46

VS 150

approved. Wm Z Kelsick MD

G43391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

G43391 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Belmont Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Belmont Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adam Alheit

3 (b) If veteran, name war --

3 (c) Social Security Account No. 218-05-1638

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Alheit

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1872

8. AGE: Years 73 | Months 11 | Days 11/0 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Merchant Tailor

11. Industry or business

FATHER
12. Name John George Alheit
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes C. Wendell
15. Birthplace Germany

16 (a) Informant Mrs. Mary Alheit
(b) Address 3017 Belmont Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) SEP 3 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 4.45

20. DATE OF DEATH September 1, 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1946 to Sept 1, 1946 and that I last saw deceased alive on Sept 1, 1946

Immediate cause of death: Carcinoma frontal — Sinus & Perit — Duration 5 days

Due to

Due to

Other Conditions Gadgets Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grant M. Kalas

Address 735 Poplar Grove St Date signed 9/3/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G43392 G43392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

Registered No.

Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2145 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah L. Day

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Robert Day
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2-1859

8. AGE: Years	Months	Days	If less than one day
87	11	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER
12. Name William A. Bright
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Ann Powell
15. Birthplace Md.

16 (a) Informant William B. Day
(b) Address 2145 Walbrook Ave

17 (a) Burial (b) Date thereof 9-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co.

18 (a) Funeral director Saml. W. Chase & Son
(b) Address 1698 N. Gilmor St.

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 6 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1946, to Aug 31 1946, and that I last saw h[illegible] alive on Aug 31 1946

Immediate cause of death	Duration
Congestive Heart failure	2 weeks
Due to Hypertension	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Mc Donald M. D.
Address 844 N Carey Date signed 9/3/46

VS 1

G43393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G43393

G43393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 N. Central Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Central Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Tenie O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph O'Brien

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1890

8. AGE: Years 55 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name John Williams

13. Birthplace md

MOTHER 14. Maiden Name Ida Matthews

15. Birthplace md

16 (a) Informant Jerome Bacon

(b) Address 419 N Central ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 3 46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location C. C. Co.

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E Preston St

19 (a) SEP 3 - 1946 (b) (Registered by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/46 19.. at 9:30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhagic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.

Date signed 8/30/46

VS 191

G43394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G43394 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement or omission of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 W. 24TH ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 3 1/2 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 W. 24TH ST (If rural give location)
(e) If foreign born, how long in U. S. A.) NO years

3 (a) FULL NAME ANNA WYNN

3 (b) If veteran, name war

3 (c) Social Security Account No. 207-05-2464

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 1 - 1917

8. AGE: Years	Months	Days	If less than one day
28	9	1	hr. min.

9. Birthplace SCRANTON, PENNA (Town, county, and state)
10. Usual Occupation INSPECTOR
11. Industry or business WESTERN ELECTRIC.

FATHER
12. Name FRANCIS A. WYNN
13. Birthplace SCRANTON, PA.

MOTHER
14. Maiden Name NETTIE DAMOUSKIKK
15. Birthplace SCRANTON, PA.

16 (a) Informant FRANCIS A. WYNN
(b) Address 6 W. 24TH ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 3 - 1946 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location SCRANTON, PENNA

18 (a) Funeral director Chas. L. Evans Son Inc.
(b) Address 118 N. Mt. Royal Ave

19 (a) Registered by registrar Huntington Williams M.D.

SEP 3 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 2 1946 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945 to Sept 2 1946 and that I last saw h[er] alive on Sept 2 1946

Immediate cause of death: Cardiac Insufficiency — Duration 45 days
Due to: Advanced Arteriosclerosis — Duration —
Due to: Acute Cystitis Coronary — Duration 14 hrs
Other Conditions: Intermittent — Duration 1 month
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roscoe G. Knox M. D.
Address 7438 Harwyn Rd Date signed Sept 2 46

G43395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G43395 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga Sts. 4th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Mercy Hosp. Calvert & Saratoga Sts (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Brennan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1868

8. AGE: Years	Months	Days	If less than one day
78	3	7	hr. min.

9. Birthplace Texas, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William Brennan
13. Birthplace Ireland

MOTHER 14. Maiden Name Genevieve O'Hara
15. Birthplace Ireland

16 (a) Informant Miss Mary Brennan
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cemetery
Location Texas, Balto. Co. Md.

18 (a) Funeral director H. W. Meagher Son
(b) Address 605 N. Calvert St.

19 (a) (Date rec'd by registrar) SEP 3 - 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1946, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Sept 1st 1946, and that I last saw her alive on Sept 1 1946.

Immediate cause of death Cardiac Insufficiency — Duration

Due to Acute Congestive Heart Failure — 48 hours

Due to Arterio-Sclerotic C-V. Disease — 10 years

Other Conditions Cancer of Sigmoid Flexure

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Brennan
Address Mercy Hosp. Date signed 9-1-46 M. D.

G43396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G43396 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2610 Huronstreet
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Wpl

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Huronstreet (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Pearl Parham

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	col.	married

6 (b) Name of husband or wife Thomas Parham
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March-3-81

8. AGE: Years	Months	Days	If less than one day
65	5	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Henry Blackburne
13. Birthplace Virginia

MOTHER 14. Maiden Name Lucinda Covington
15. Birthplace Virginia

16 (a) Informant Margret Hedgeman
(b) Address 2610 Huronstreet

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (date received by registrar) Sept 3 1946 (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August-29-1946, at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1- 1946 to Aug-29-1946, and that I last saw h er alive on August 19 1946.

Immediate cause of death: Congestive heart failure — Duration: about 2 months

Due to: chronic myocarditis

Due to:

Other Conditions: cancer of the uterus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walther H. Sonnenfeldt M. D.
Address 2708 Hollins Ferry Road Date signed 8/29/46

Sonnenfeldt

G43397 John Gould
14 N. East Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 8313

G43397 Registered No.

The entry of information should be carefully supplied. Every item, with ONE ADDING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2874 Kentucky Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2874 Kentucky Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Joseph Francis

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7546

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Anna A. Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1882

8. AGE: Years	Months	Days	If less than one day
64	4	2	hr. min.

9. Birthplace Fairfield, Conn.
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name James Francis
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Anna A. Francis
(b) Address 2874 Kentucky Avenue

17 (a) Burial (b) Date thereof 9-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road,

SEP 3 - 1946
(Date rec'd by registrar) Huntington Hollins M.D. Hospital

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1st, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1946 to 9-1 1946 and that I last saw him alive on 9-1 1946.

Immediate cause of death: Cerebral thrombosis — Duration 3 mo.
Due to Cerebral arteriosclerosis
Due to General arteriosclerosis
Other Conditions Myocardosis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J J Gould M. D.
Address 1426 East ave Date signed 9-2-46.

G43398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137ai

Registered No. G43398

Every item of information should be carefully supplied. Write with UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3209 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Lawrence Denton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Phoebe Weck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1862

8. AGE: Years	Months	Days	If less than one day
83	10	14	hr. min.

9. Birthplace Hempstead, Long Island.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER FATHER

12. Name Samuel H. Denton

13. Birthplace Hempstead, Long Island

14. Maiden Name Rebecca Rhodes

15. Birthplace Hempstead, Long Island

16 (a) Informant Mrs. Elmer Potter

(b) Address 3209 Northern Parkway

17 (a) Burial (b) Date thereof 9-5-46.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodland Pk

Location Balto

18 (a) Funeral director Leonard J. Luck

(b) Address 5305 Harford Road-14-

SEP 3 - 1946 (Date rec'd by registrar) Clayton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1946, at 8:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1946, to Sept. 2 1946, and that I last saw him alive on Aug. 22 1946.

Immediate cause of death Myocardial failure — Duration

Due to Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan. 1946

Major findings of operation: Enlarged prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Donald Landon M. D.

Address 6077 Harford Rd. Date signed Sept 4, 1946

X

G13399

CWK-95206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43399 Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important. WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0 28 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Smithson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 6-1919

8. AGE: Years	Months	Days	If less than one day
26	10	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Howard
13. Birthplace Maryland

MOTHER
14. Maiden Name Janie Jackson
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Wes. H. Nelson
(b) Address 1303 Pennsylvania Ave
19 9-3-1946 (Date rec'd by registrar) Thurlington Williams Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Aug. 31 1946, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1945 to Aug. 31 1946 and that I last saw her alive on Aug. 31 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to	
Due to Pulmonary Tuberculosis	
Other Conditions Laryngeal Tuberculosis (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. K. Hartzoragh M. D.
Address Balto. City Hosp. Date signed 9-1-46

G13400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G13400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 S. Ann St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Ann st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Gehrmann (Gehrmann)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business

FATHER 12. Name Wilhelm Gehrmann
13. Birthplace —

MOTHER 14. Maiden Name Elis. Haenni
15. Birthplace —

16 (a) Informant C. Walch
(b) Address —

17 (a) Burial (b) Date thereof Sept 6 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Locust Hill Mem.
Location Gloucester Hall Rd

18 (a) Funeral director Selby & Zieler, Inc.
(b) Address 403 S. Wolfe St.

SEP 3 - 1946 Huntington Williams M.D.
(Date Rec'd by Local Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1946, at 4.20 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Left cerebral hemorrhage

Due to Arteriosclerosis
Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/3/46

Please write the causes of death clearly and legibly. Type or print all entries except signatures. Be careful and complete. Answer all questions as carefully supplied.

G43401 B.C.H.D. 55347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 161c

Registered No. G43401

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 1213 Lytle St.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Lytle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kidd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 31 Aug 46

8. AGE: Years | Months | Days 1 2 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Lee Kidd
13. Birthplace Virginia.

MOTHER
14. Maiden Name Margaret Louise Parker
15. Birthplace Stratton, Pa.

16 (a) Informant Margaret Kidd
(b) Address 2433 Keyway, Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave

18 (a) Funeral director John F. Denny Inc
(b) Address 711 Light St.

19 (a) Date received SEP 3 1946 (b) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Sept. 1946, at 12:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Aug 1946, to 2 Sept 1946 and that I last saw h[illegible] alive on 2 Sept 1946.

Immediate cause of death Hemorrhage in Disease of Newborn

Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operation:

of autopsy: Hemorrhage duodenum Intestine

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cohen M. D.
Address South Balto Gen'l Hosp. Date signed 2 Sept '46

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43403 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G43402

CERTIFICATE OF DEATH

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Argyle Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1897

8. AGE: Years 49 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Marcellus Brown

13. Birthplace Howard Co. Md.

MOTHER — 14. Maiden Name Mary Cornish

15. Birthplace Cambridge, Md.

16 (a) Informant Mrs. Helen Brown

(b) Address 1015 Argyle Avenue.

17 (a) Burial (b) Date thereof 9/3/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Zion

Location

18 (a) Funeral director G. Halstead

(b) Address 918 Druid Hill Ave.

19 SEP 3 - 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1946 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to August 1946 and that I last saw h[illegible] alive on 8/28/1946

Immediate cause of death [illegible]

Due to Lung Abscess

Due to Complication of Pneumonia & Lobar

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 130 N. Fremont Ave. Date signed 9/2/46

Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G43403

490 012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G43403 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 E. Rombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 3-8-71

8. AGE: Years	Months	Days	If less than one day
75	5	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Md

MOTHER
14. Maiden Name Sara Perry
15. Birthplace Md.

16 (a) Informant Rec'nda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4-46 (month) (day) (year)
(c) Cemetery or crematory Popular Grv. Location Wagner Balto. Co. Md.
18 (a) Funeral director John A. Meltz
(b) Address 2334 Jefferson St.
19 (a) (Date rec'd by registrar) (b) Registrar, M.D.

VS no SEP 3 - 1946 Huntington Williams

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept- 2 1946 at 1.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-31 1946 to Sept-2 1946 and that I last saw him alive on Sept-2 1946

Immediate cause of death	Duration
Thrombosis of cerebral vessels	
Due to Generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Marion B. Day M. D.
Address Johns Hopkins Hosp Date signed 2 Sept 46

X

G43404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F

G43404 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 S. Chester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wojciech Placek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Basket Maker

11. Industry or business

FATHER
12. Name Jan Placek
13. Birthplace Poland

MOTHER
14. Maiden Name Karolina Wojciecka
15. Birthplace Poland

16 (a) Informant Agnes Placek
(b) Address 214 S. Chester St

17 (a) Burial (b) Date thereof Sept. 7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto, City

18 (a) Funeral director Wm. J. Flaherowski
(b) Address 2007 Eastern ave

19 (a) SEP 3 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

LVS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Sept 3 1946 and that I last saw him alive on Sept 2 1946

Immediate cause of death
Carcinoma of Throat — Duration 2 yrs.

Due to

Due to

Other Conditions Metastatic Carcinoma Liver — Duration 4 mos.
(Include pregnancy within 3 months of death)

Date of operation March 1946

Major findings of operation: Carcinoma Throat

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury

23. Signature Huntington Williams, M.D.
Address 1802 Eastern Ave Date signed 9-3-46

X

G43405 BALTIMORE CITY HEALTH DEPARTMENT X V G43405
CERTIFICATE OF DEATH 49a Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPE OR PRINT IN INDELIBLE PENCIL OR PEN AND INK. WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland - 31
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life - 36yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - 6, Overlea (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Old Home Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Grace Ross

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles J. Ross.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 20, 1909
8. AGE: Years 36 | Months 10 | Days 13 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business

FATHER
12. Name Columbus Jacques
13. Birthplace Michigan

MOTHER
14. Maiden Name Mary Dawson
15. Birthplace Maryland

16 (a) Informant Husband
(b) Address 701 Old Home Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto. Md.
18 (a) Funeral director Lansdale Funeral Home
(b) Address 401 Belair Road
19 (a) (Date) 9-3-1946 (b) Huntington Williams M.D. (registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1946 at 7 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20, 1946 to Sept 2, 1946 and that I last saw her alive on Sept 2, 1946.

	Duration
Immediate cause of death: Heart Failure	Terminal
Due to Carcinomatosis generalized	2yrs +
Due to Papillary adenocarcinoma of ovary	2yrs +
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 20, 1946
Major findings of operation: Papillary Ca of ovary & peritoneal metastases.
If autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayne N. Jacobus, M.D.
Address Church Home & Hosp. Date signed 7/24/46

X

G43406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43406 Registered No.

CHK-105729

1 Please print in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Dover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Millner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Unknown

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
70	?	?	? hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Harry Millner
13. Birthplace ?

MOTHER 14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 26 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 3 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 46 at 5: M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1946 to Aug. 15 19 , and that I last saw h im alive on Aug. 15 19 46.

Immediate cause of death: Intracranial hemorrhage — Duration: 1 week
Due to: Head injury — 7 week
Due to: Fracture of skull
Other Conditions: Pneumonia — 1 week
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 27 1946 at A.M
(c) Where did injury occur? City Jail - Baltimore
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? City Jail While at work? No
(Specify type of place)
(e) Means of injury Fell down floors
23. Signature R. Rowe Hoffman M.D.
Address Baltimore City Hosp Date signed 22 Aug 46

VS 150

Certificate to be approved by the Medical Examiner
Thomas L. Mackenzie, M.D.

G43407 BC.g.50276 BALTIMORE CITY HEALTH DEPARTMENT ✓ G43407
Registered No.

CERTIFICATE OF DEATH 160a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INDELIBLE INK. EVERY ITEM MUST BE FILLED IN.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 W Franklin St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 W Franklin
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Paul Edward Lawson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1946

8. AGE: Years — | Months — | Days 1 | If less than one day [illegible] hr. 30 min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Anthony Lee Pritchard

13. Birthplace Dinwitty, Virginia

MOTHER 14. Maiden Name Palmetta Lawson

15. Birthplace Kingston, N.C.

16 (a) Informant Palmetta Lawson

(b) Address 1020 W. Franklin St. Balto.

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day) (year)

(c) Cemetery or crematory [illegible]

Location Johns Hopkins Medical Schoo SEP 3 1946

18 (a) Funeral director [illegible] Commissioner of Health

(b) Address [illegible]

19 SEP 3 1946 [illegible] Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Aug 1946, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Aug 1946, to 30 Aug 1946, and that I last saw him alive on 30 Aug 1946.

Immediate cause of death Cardiac Respiratory Failure — Duration —

Due to Pulmonary Atelectasis —

Due to — —

Other Conditions Intracranial Hemorrhage —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)

(e) Means of injury —

23. Signature C Lawrence W Mayhew M. D.

Address University Hosp Date signed 30 Aug 46

VS 150

161a

G43408 INMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC.G. 55126 159 G43408 Registered No. 24247

Every item of information should be carefully supplied. TYPEWRITE, WITH UNFADING INK. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2103 Ehrenwood Ct.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Ehrenwood Ct. (If rural, give location)
(e) Citizen of foreign country? Neg (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Inman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Col.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/46

8. AGE: Years	Months	Days	If less than one day
0	0	0	8 hr. 0 min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Rufus Inman
13. Birthplace Rollins N.C.

MOTHER
14. Maiden Name Ezzie Mae Barnes
15. Birthplace Wayne Co. N.C.

16 (a) Informant C. M. Inman
(b) Address 2103 Ehrenwood Ct.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo SEP 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 3 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1946 at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1946 to 8/31 1946 and that I last saw her alive on 8/30 1946.

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Lightstone Jr M. D.
Address 501 Cherry Hill Rd Date signed 8/31/46

G43409 BALTIMORE CITY HEALTH DEPARTMENT G43409
CERTIFICATE OF DEATH 93 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3132 ELLERSLIE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 ELLERSLIE AVE
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME MARY ALICE BALDWIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife BENJAMIN M. BALDWIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 26 1877

8. AGE: Years	Months	Days	If less than one day
69	7	5	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name ALBERT T. HOPKINS
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name MARY EDSMITH
15. Birthplace BALTIMORE, MD

16 (a) Informant MRS. MARIE M. McAULIFFE
(b) Address 3132 ELLERSLIE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 118 N. Mt. Royal Ave

SEP 3 - 1946 (a) (b) for Williams M.D. Registrar
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1946 to Aug. 31, 1946 and that I last saw her alive on Aug. 31, 1946;

Immediate cause of death: Myocardial Failure — Duration: Immediate

Due to Chronic Myocarditis — 1 year

Due to ✓ ✓

Other Conditions ✓ ✓

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St Date signed Sept. 3, 1946

G43430 G43430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Eutaw Place
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Eutaw Place
(If rural give location)
(e) If foreign born, how long in U. S. A.? 50 YRS. years

3 (a) FULL NAME PATRICK J. DUNPHY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Winifred Haney Dunphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 8 - 1884

8. AGE: Years 62 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace IRELAND (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name JOHN DUNPHY
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARGARET MAC DONALD
15. Birthplace IRELAND

16 (a) Informant MISS MARY DUNPHY
(b) Address 1316 EUTAW PLACE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/5/46 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 113 W. Mt. Royal Ave

19 (a) SEP 3 - 1946 (Date rec'd by registrar) (b) [illegible] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Sept 2 1946 and that I last saw h(im) alive on 2 Sept 1946

Immediate cause of death Chronic myocarditis — Duration

Due to hypertension, - age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide — No
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G Lane Taney Hill M.D.
Address 1316 Eutaw Place Date signed 2 Sept 1946

Physicians: please write the causes of death clearly and legibly.

G43411

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43411 Registered No.

CERTIFICATE OF DEATH 124B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 Northway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Northway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Ellis Mahon

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John D.
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1892

8. AGE: Years 53 | Months 9 | Days 11 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation --
11. Industry or business --

FATHER
12. Name Jos. A. Ellis
13. Birthplace Penna.

MOTHER
14. Maiden Name Gertrude L Tate
15. Birthplace Penna.

16 (a) Informant Mr. John D. Mahon
(b) Address 226 Northway (Guilford)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2c46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Charles E. Delosier
(b) Address Ellicott City

SEP 3 - 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1942 to Aug 30 1946 and that I last saw h alive on 19

Immediate cause of death Chr. Myocarditis

Duration 3 mos

Due to

Due to

Other Conditions Arteriosclerosis Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify kind of place)
(e) Means of injury

23. Signature James H Howard M. D.
Address 715 Fredrica Rd Date signed 8-31

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Use BLACK INK.

VS 180

G43412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G43412
Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 Bergundy St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Bergundy St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BELTON-R·REY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Carolina

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 20 1883

8. AGE: Years	Months	Days	If less than one day
63	—	13	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER
12. Name Norman Rey
13. Birthplace Virginia

MOTHER
14. Maiden Name Mc Kinnon
15. Birthplace Virginia

16 (a) Informant Carolina Rey
(b) Address 800 Bergundy St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk
Location Woodlawn Md

18 (a) Funeral director Geo Lennbach
(b) Address 1414 N. Fremont St

19 9-6-1946 Huntingtown Williams, MD
(Deputy city registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1946 at 8a M

22. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1946 to 9-2 1946 and that I last saw him alive on 9/2 1946

Immediate cause of death

	Duration
Acute Cardiac Failure	1 da
Due to Arteriosclerosis Renal Disease	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph T. Lankester
Address 1 E Washington St Date signed 9/3/46

VS 150

043413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. 043413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 E. Pratt St
(c) Hospital or Institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Gentry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles H. Gentry

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1904

8. AGE: Years 41 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Salvatore Barone
13. Birthplace Naples Italy

MOTHER
14. Maiden Name Gertrude Esposito
15. Birthplace Naples Italy

16 (a) Informant Charles H. Gentry
(b) Address 2123 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Ritchie Highway

18 (a) Funeral director Fred A. Evans & Son
(b) Address 216 N. Charles St.

19 (a) (b) Hunter G. Williams, M.D. Registrar

Date rec'd by registrar SEP 4 - 1946

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1946 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1946 to Sept 1 1946, and that I last saw h[illegible] alive on Sept 1 1946.

Immediate cause of death Bronchopneumonia — Duration 7 Days

Due to acute Lo Grippe. — Duration 3 wks.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted] M. D.
Address 644 [redacted] Date signed Sept 9/46

CORRECTION. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G13414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G13414 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3603 Grantley Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Grantley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD J. HABERCAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice O. Habercam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1890

8. AGE: Years	Months	Days	If less than one day
55	9	7	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Commercial Traveler
11. Industry or business Dennison Mfg. Co.

FATHER
12. Name John Habercam
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sophia Mitchell
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Alice O. Habercam
(b) Address 3603 Grantley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 4 - 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1946, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10, 1946 to Sept. 1 1946, and that I last saw him alive on Sept. 1, 1946

Immediate cause of death Pulmonary Tuberculosis — Duration 3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signatory Carling J. Dawes, M. D.
Address 800 N. Eutaw St. Date signed 9-3-46

X

G43415

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43415
CERTIFICATE OF DEATH 131a
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1935 West Lexington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1935 West Lexington st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD G. DAVIS HOWARD G. DAVIS

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-07-6378

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Addie B. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/30/1881

8. AGE: Years	Months	Days	If less than one day
65	2	1	********** hr. ********** min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Monumental Improv.Co.

FATHER
12. Name Charles E. Davis
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma L. Wambach
15. Birthplace Maryland

16 (a) Informant Mrs. Addie B. Davis
(b) Address 1935 W. Lexington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 Sept. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director C. B. Shubert & Son
(b) Address 1300 Eutaw Place..c

19 (a) SEP 4 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by Local Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1st. Sept 46 19 , at 5:A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to Sept 1 1946 and that I last saw him alive on Sept 1 1946

Immediate cause of death: Arteriosclerotic Cardiovascular disease — Duration: 2 y.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Laughlin M. D.
Address 400 N. Payson St. Date signed 9/3/46

X

G43416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200 C

G43416 Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. The accuracy of the statements made by the attending physicians is necessary.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL R. KLEIN

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 705-05-6155

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband/wife: Margaret [redacted] A. Meier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, [redacted] 1897

8. AGE: Years 48 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business B. & O. R.R.

FATHER
12. Name Ferdinand Klein
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Annie ?
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary A. Meier
(b) Address 233 E. Heath Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4, 1946 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Frederick Rd.

18 (a) Funeral director McCully Funeral Home
(b) Address 1946 Fort Ave.

19 (Date rec'd by registrar) SEP 4 1946 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1946, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Unknown

Due to

Other Conditions Practically a skeleton

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 9-4-46

VS 151

G43417

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43417
Registered No.

CERTIFICATE OF DEATH

50

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hamplet & List Aves
(c) Hospital or institution:
Pine Ridge Con.Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Old Home Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M.Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24.1878

8. AGE: Years	Months	Days	If less than one day
68	3	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Maeser
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Germany

16 (a) Informant Thomas B.Gosnell
(b) Address 1616 E.Lanvale St.

17 (a) Burial (b) Date thereof Sept.5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Sterling Sons
(b) Address 2024 Orleans St.

19 SEP 4 1946 Huntington Williams, M.D.
Date received by Registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.2.1946 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/45 19 to 9/2/46, and that I last saw her alive on 9/2/46

Immediate cause of death Carcinoma of Breast — Duration 2 yrs

Due to

Due to

Other Conditions Myocarditis Deg. 1 wk

(Include pregnancy within 3 months of death)

Date of operation June 1945

Major findings of operation: Carcinoma

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W Hurwitz M. D.
Address 1710 E 32nd St Date signed 9/4/46

VS 150

G43418 G43418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 E. University Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife James Edward | 6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec 17-1903

8. AGE: Years 45 | Months 8 | Days 14 | If less than one day: hr. min.

9. Birthplace Joppa Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Julius Brown
13. Birthplace Md

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Bertha B. Brown
(b) Address 300 E. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1946 (month) (day) (year)
(c) Cemetery or crematory Asbury Cem.
Location Lorley Md

18 (a) Funeral director Mrs. Lott O. Ellwood Dept
(b) Address 1189 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md

SEP 4 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1946, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1946, to 9-1 1946, and that I last saw h[illegible] alive on 9-1 1946

Immediate cause of death: Mitral Insuff'ency — Duration: Sept

Due to Acute dilatation

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edw Fisher

Address 612 E. Monument Date signed 9-2 1946 M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G43419 G43419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT IN INDELIBLE INK, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4514 Pimlico Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Cohen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Julius
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Pk
Location Woodlawn Mem Pk

18 (a) Funeral director Jacob Levin Inc
(b) Address 1432 E. Balto St.

19 (a) SEP 4 - 1946 (Date rec'd by registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1946, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1946, to Sept 3 1946, and that I last saw her alive on Sept 3 1946.

Immediate cause of death: Circulatory Failure — Duration

Due to Hemorrhage Chronic

Due to Carcinomatosis From Carcinoma of colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 23, 1946

Major findings of operation: Contusion of transverse ileocolostomy site.

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Perlman
Address Sinai Hospital Date signed Sept 3, 1946 M. D.

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43120 Registered No.

CERTIFICATE OF DEATH 46E

G43120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Fulton, R.F.D. #1 (If outside city or town limits, write RURAL and give town)
(d) Street No. Old Columbia Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Herman Yager

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) July 21, 1880.
8. AGE: Years 66 Months 1 Days 12 If less than one day hr. min.
9. Birthplace Fulton, Howard Co. Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Farming

FATHER
12. Name Henry R. Yager
13. Birthplace Howard Co. Maryland

MOTHER
14. Maiden Name Caroline Krauss
15. Birthplace Fulton, Maryland.

16 (a) Informant Mr. Leo. Edw. Yager
(b) Address Laurel, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Fulton Lutheran Cem. Location Fulton, Maryland

18 (a) Funeral director Easton, Sons
(b) Address Ellicott City, Maryland

19 (a) (Date rec'd by Registrar) (b) [illegible] Registrar

SEP. 4 - 1946

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1946 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Sept. 2 1946, and that I last saw h[illegible] alive on Sept. 2 1946.

Immediate cause of death: Generalized Carcinomatosis — Duration: 4 mos.
Due to: Carcinoma - Caecum — ? —
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Klemann M. D.
Address 3823 Edmondson Date signed 9/4/46.

X

TYPE OR PRINT IN PERMANENT BLACK INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111 C

G43421

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2553 McCulloh St.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2553 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Lykes

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-6532

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/0

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Columbia S.C.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Hilliard Lykes

13. Birthplace Columbia, S.C.

MOTHER 14. Maiden Name Nellie Knight

15. Birthplace Columbia S.C.

16 (a) Informant Mrs. Estelle Lykes

(b) Address 2553 McCulloh St.

17 (a) Burial (b) Date thereof 9/6/1946
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Kate N. Stallard

(b) Address 163 Druid Hill Ave.

19 (a) Filed SEP 4 1946 (b) Registrar Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1946 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy & thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed Sept. 2, 1946

Howard J. Lawrence M.D.

643222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Roberts Ave C'Ville (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Eastern Shore

3 (a) FULL NAME Louvenia Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race N

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-66 1880

8. AGE: Years 80 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation H' Wife

11. Industry or business

MOTHER / FATHER

12. Name Joshua Thomas

13. Birthplace Montgomery Co. Md

14. Maiden Name Annie Maria

15. Birthplace Howard Co. Md.

16 (a) Informant John H. Matthews

(b) Address 3 Roberts Ave. - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1946 (month) (day) (year)

(c) Cemetery or crematory Western Star

Location Catonsville, Md.

18 (a) Funeral director Mrs. Laws. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) SEP 4 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 2 1946, at 10 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8-6 1946, to 9-2 1946, and that I last saw her alive on 9-2 1946.

Immediate cause of death: Septcomia — Duration

Due to Gangrene of left Great Toe

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr G. F. Phillips A White M. D.

Address Provident Hosp Date signed 9-3-46

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

TYPE OR PRINT PLAINLY, WITH UNFADING INK.

643423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

643423 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PLAIN, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Etting St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Colbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1897

8. AGE: Years 49 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Colbert
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Jolly
15. Birthplace Md

16 (a) Informant Mrs. Lillian Colbert
(b) Address 1128 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/1946 (month, day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Geo. T. A. Gibson Co.
(b) Address 1735 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1946 at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1946 to Aug 31 1946, and that I last saw h[illegible] alive on Aug 31 1946.

Immediate cause of death	Duration
Cirrhosis of the liver	
Due to	
Due to	
Other Conditions Unspecified	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Bayfield, M. D.
Address 7227 Belvedere Date signed 9/4/46

VS 180

G43424 G43424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No. 939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 Clyde Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY T. McCANN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife THOMAS A (DEAD)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 13-1869

8. AGE: Years 77 | Months 3 | Days 32 | If less than one day ____ hr. ____ min.

9. Birthplace BALTO - MD (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name ANTHONY BERGHOFF

13. Birthplace GERMANY

MOTHER 14. Maiden Name ANNA VERSTEG

15. Birthplace GERMANY, (MARYLAND)

16 (a) Informant MARY HITSELBEGER

(b) Address 146 CLYDE, LANDOWNE MD

17 (a) BURIAL (b) Date thereof Sept. 6-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRAL

Location BALTO CITY.

18 (a) Funeral director JOHN R KENNY

(b) Address 1242 LEEDSTER AVE Balto 5 MD

19 (a) (b)
(Date received by registrar) (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/46 19 , at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions Fractured Wrist
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [X] cause of death, fill in the following:

(a) Date of injury 9/3/46 at 1:00 P.M.

(b) Where did injury occur? Home

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury fell down steps

23. Signature John R Ward M.D.
Medical Examiner.

Date signed 9/3/46

Huntington Williams, MD

X

G43425 G43425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Gay Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ANTHONY SIMMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-7976

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1889

8. AGE: Years 35 | Months 11 | Days 20 | If less than one day: hr. min. 1910

9. Birthplace Morgan County Tennessee
(Town, county, and state)

10. Usual Occupation Soldier

11. Industry or business

FATHER 12. Name Fellmore Anthony

13. Birthplace Morgan Co Tennessee

MOTHER 14. Maiden Name Caroline Jones

15. Birthplace Morgan Co Tennessee

16 (a) Informant Mrs Brown

(b) Address 900 N Gay st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4, 1946 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn

Location Baltimore city

18 (a) Funeral director Sollers Sons

(b) Address 1408 Eastland ave

19 (a) Huntington Williams (Name rec'd by registrar)

SEP 4 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946 at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary disease
Hypertrophy & dilatation of heart
DUE TO Emphysema of lungs
Early cirrhosis of liver
Other Conditions Nephrosclerosis; Arteriosclerosis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Clements M.D.
Medical Examiner.
Date signed 8/22/46

G43426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

G43426 Registered No.

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 Wheeler Ave
(c) Hospital or institution N.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 W Wheeler Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francesco Marconi
3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none
4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of wife: Agata Marconi
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 11 1870
8. AGE: Years 75 Months 10 Days 23 If less than one day hr. min.
9. Birthplace Chiarino Teramo Italy (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name Raffaele Marconi
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Michele Urbani
15. Birthplace Italy

16 (a) Informant Agata Marconi (Wife)
(b) Address 32 Wheeler Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.6 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederik Rd. Baltimore Md.
18 (a) Funeral director Leonard Della Rose
(b) Address 52 N Marley St.
19 (c) SEP 4 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1946, at 11:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1946 to 9/8 1946 and that I last saw him alive on 9/2 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arterio Sclerosis	
Due to	
Other Conditions Carcinoma of Tongue (Include pregnancy within 3 months of death)	5 yrs

Date of operation 8/1 - 46
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward Parker, M.D.
Address 245 N Belto Date signed 9/9/46

VS 150

35-606 G43127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43127 Registered No.

141F

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Alston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace NC (Town, county, and state)
10. Usual Occupation work in government plant
11. Industry or business

FATHER
12. Name Wiley Battle
13. Birthplace NC

MOTHER
14. Maiden Name Julia Simoné
15. Birthplace N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 9 4 46 (month) (day) (year)
(c) Cemetery or crematory Rodeney Mount
Location N. C.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 1946 Registered by registrar Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1946 at 10 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1946 to Aug. 31 1946 and that I last saw h[illegible] alive on Aug. 31 1946

Immediate cause of death — Duration

Peritonitis — 14 day

Due to abortion, ? criminal — 15 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan
Address 109 N. Broadway Date signed 9-1-46

Howard J. Moseley, M.D. X

G43428 BC.9.65913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G43428 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and name town)
(d) Street No. 2648 Loyola Southway
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Joyce Beth Leibensperger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Baby

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1946

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Elmer W Leibensperger
13. Birthplace Mexico

MOTHER 14. Maiden Name Marjorie Bernstein
15. Birthplace Balto Md.

16 (a) Informant Elmer Leibensperger
(b) Address 3648 Loyola Southway

17 (a) Burial (b) Date thereof Sept 7, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Baltimore City

18 (a) Funeral director Harold Sondheim & Son
(b) Address 1904 Eutaw Place

19 (a) Date received SEP 4 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1946, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1946 to 9/4 1946, and that I last saw h[illegible] alive on 9/4 1946

Immediate cause of death Laparotomy 4 hrs. (right lower & left upper abdomen) — Duration

Due to Post operative

Due to

Other Conditions Intestinal Obstruction Peritonitis
(Include pregnancy within 3 months of death)

Date of operation 9/2/46

Major findings of operation: Congenital stenosis of ileum

of autopsy: Pneumonia, bilateral post mortem

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney Green M.D.
Address Sinai Hospital Date signed 9/4/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G43429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G43429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821. Sarah Ann. st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821. Sarah Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus Murray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	— ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68 yrs.	—	—	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation ~~Laborer~~ preacher

11. Industry or business

FATHER
12. Name — Murray
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name unknown
15. Birthplace Calvert Co Md

16 (a) Informant Mable Johnson
(b) Address 916. parrish st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Pat. Balti md

18 (a) Funeral director Metropolitan Fun. Home Inc.
(b) Address 927. N. mount st.

19 (a) (Signature of 'by direction') (b) Sept 1 1946 Washington Ville md

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 August 1946, at 4 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer 3d M.D. (Medical Examiner.)
Date signed 31 August 1946

...ause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

G43130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G43130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Carrington Ave. N. Collington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anne Tudor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Howard W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1867

8. AGE: Years 78 | Months 3 2 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Rooney
13. Birthplace Irland

MOTHER
14. Maiden Name Anne McCartney
15. Birthplace Irland

16 (a) Informant Charles Tudor
(b) Address 2730 E. Biddle Street

17 (a) Burial (b) Date thereof Sept. 7, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Road

18 (a) Funeral director Leland E. Zickler Sons
(b) Address 403 S. Wolfe Street

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1946, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4- 1946 to 9-3- 1946 and that I last saw h[illegible] alive on 9-3- 1946.

Immediate cause of death — Duration

Central Hemorrhage

Due to Adv. atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Jacob M. D.
Address 1700 Eutaw Pl. Date signed 9-4-46

vs SEP 4 - 1946 Huntington Williams, M.D.

(17)

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINTED WITH UNFADING INK.

G43431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43431 Registered No.

1. PLACE OF DEATH: D. H.
(a) Baltimore City, Maryland
(b) Street address 110 E. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ludwig Karalus (Ludwikas Karalavs)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1872

8. AGE: Years 74 | Months 5mt | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Karalus
13. Birthplace Lithuania

MOTHER
14. Maiden Name Unknown
15. Birthplace Lithuania

16 (a) Informant Mrs. Elizabeth Pocka
(b) Address 842 W. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 44 70 Baltimore Rd

18 (a) Funeral director John J. Howard & Son
(b) Address 96-05 Hollins St.

19 (a) SEP 4 (Date received by registrar) (b) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1946, at 10 25 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/4/46

VS 191

Huntington Williams, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1220

G43432 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Parkin St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eugenia R Vagelis
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-07-9568

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/13/96

8. AGE: Years	Months	Days	If less than one day
49	11	24	20 hr. min.

9. Birthplace Europe (Town, county, and state)
10. Usual Occupation seamstress
11. Industry or business

FATHER
12. Name Stanley Rodowskas
13. Birthplace Europe

MOTHER
14. Maiden Name Elizabeth Skogeris
15. Birthplace Europe

16 (a) Informant Joseph Vagelis
(b) Address Ellicott City, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Leland Rd.

18 (a) Funeral director Charles W. Faehnrich
(b) Address 703 ME Henry St

19 (a) (b)
Certificate rec'd by registrar SEP 4 - 1946
Signature of Registrar for William Reich M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 19 46 at 2:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1946 to 9/3 1946, and that I last saw h[illegible] alive on 9/2 1946.

Immediate cause of death	Resp. failure	Duration
Due to	Intestinal Obst.	
Due to	adhesions	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. O. Carleton
Address So Balto Gen Hosp Date signed 9/3/46 M. D.

X

G43433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

G43433 Registered No.

Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mittie Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21

8. AGE: Years 10 | Months | Days | If less than one day hr. min.

9. Birthplace Sussex Va.
(Town, county, and state)

10. Usual Occupation School.

11. Industry or business

FATHER
12. Name Daniel Lewis
13. Birthplace Va.

MOTHER
14. Maiden Name Maxine Green
15. Birthplace Va

16 (a) Informant Maxine Green.
(b) Address 1400 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/46 (month) (day) (year)
(c) Cemetery or crematory Little Mount Ch
Location Sussex co Va

18 (a) Funeral director Metropolitan Fun Home
(b) Address 927 N. Monroe St.

19 (a) [illegible] Huntington Williams M.D.
(Filled in by registrar)

Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1946, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH
Chronic Myocardio Fibrosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lubin M.D.
Medical Examiner.
Date signed 9/9/46

X

C43434 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. C43434

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution Lyndenham Hospital 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Woodyear St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Barbara Jane Watkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 2, 1944

8. AGE: Years	Months	Days	If less than one day
2	2	0	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Joseph T. Johns
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Viola Watkins
15. Birthplace Baltimore, Md.

16 (a) Informant Grandmother, Edelle Woodi
(b) Address 1128 Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 '46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) SEP 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1946 at 3:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1946 to 9-2 1946 and that I last saw h[illegible] alive on 9-2 1946.

Immediate cause of death Tuberculous meningitis — Duration 16 days

Due to

Due to

Other Conditions Mediastinal tuberculosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Lyndenham Hosp Date signed

VS 150

X

G43435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G43435 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3216 Ellerslie Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3216 Ellerslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Captain Francis A Finch

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Angeletta A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 23, 1881

8. AGE: Years 64 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace: Hoosick Falls N.Y. (Town, county, and State)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Joseph A Finch
13. Birthplace: Mass

MOTHER
14. Maiden Name: Adonia E Cassett
15. Birthplace: Mass

16 (a) Informant: John Caspari
(b) Address: 3216 Ellerslie Ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Lutheran Cemetery
Location: Hartsdale N.Y.

18 (a) Funeral director: Gilbert Colonial Home
(b) Address: 1449 Park Ave

19 (a) SEP 5 - 1946 (Date rec'd by registrar)
(b) Burial permit issued by: Harrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 4 1946 and that I last saw him alive on Sept 3 1946.

Immediate cause of death: Pulmonary Hemorrhage — Duration, 10 Mins.

Due to: Cancer of Lung — 2 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 16 Aug 1946

Major findings of operation: Cancer of Lung (Left).

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H Vanderhooper M.D.
Address: 3534 Ellerslie Date signed: 4 Sept 46

VS 150

G43436 396861

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH √61

G43436
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Yenkin Drive, Englishtown (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Katholening

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Matthew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 10-9-71

8. AGE: Years: 74 | Months: 10 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Czechoslovakia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Steininger
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden Name: Rosa (Unknown)
15. Birthplace: Czechoslovakia

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St.

19 (a) SEP 5 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3, 1946 at 5:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 27 1946 to Sept 3 1946 and that I last saw her alive on Sept 3 1946

Immediate cause of death	Duration
Cerebral hemorrhage	3 wks
Due to: Hypertension, essential	unknown
Due to	
Other Conditions: Diabetes mellitus	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Robert E. Mason M. D.
Address: Johns Hopkins Hosp. Date signed: 4 Sept 46

VS 150

83a

G43437 BC# F67297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No. G43437

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 N. Luzerne St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert T. Garrett Jr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1943

8. AGE: Years	Months	Days	If less than one day
3 yrs.	7	15	hr. min.

9. Birthplace [illegible] Balto, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert T. Garrett, Sr.
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Josephine Marie Tumimello
15. Birthplace Baltimore, Md

16 (a) Informant Robert T. Garrett
(b) Address 1030 N. Luzerne St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) SEP 5 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1946. at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 p.m. 9-3 1946. to 10:40 p.m. 9-3 1946. and that I last saw him alive on 10 p.m. 9-3 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Myocardial Failure	
Due to Anesthesia?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-3-46
Major findings of operation: Enlarged Thymus and generalized Lymphadenopathy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place) ?
(e) Means of injury

23. Signature James V. Minor, Jr. M. D.
Address Mercy Hosp. Date signed 9-3-46

X

G43438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G43438
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2524 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL CECELIA KRISS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Henry George Kriss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1919

8. AGE: Years	Months	Days	If less than one day
27 yrs.	4	25	hr. min.

9. Birthplace Newark, N. J. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Hoffberger's

FATHER
12. Name Stephen Smolek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Pauline Hecko
15. Birthplace Czechoslovakia

16 (a) Informant Henry G. Kriss - husband
(b) Address 2524 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4450 Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) SEP 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1946, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941, to Aug 3 1946, and that I last saw him alive on 9-3 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis	7 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. W. Jacobson M. D.
Address 2310 Eutaw Place Date signed 9-4-46

M. W. Jacobson X

G43439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G43439 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 N. Bentlou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA GOLDFEIN GELFAND

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Oscar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Jeff
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Lenmer
15. Birthplace Russia

16 (a) Informant Jerome Goldfein
(b) Address 1433 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Berean Rest
Location Bowley's Lane

18 (a) Funeral director SOL LEVINSON & BROS.
(b) Address 1124-26 W. North Ave.

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

SEP 5 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, '46 1946, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1946 to 9/3 1946 and that I last saw h Sr alive on 9/3 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs
Due to Hypertension, Essential	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr M.S. Shuling M. D.
Address 2426 Eutaw Pl. Date signed 9/5/46

G43140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 53

G43140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 265 S.Robinson Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 265 S.Robinson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Barbara Gostomski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband John Deceased — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1865

8. AGE: Years 81 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Un
13. Birthplace Un

MOTHER
14. Maiden Name Un
15. Birthplace Un

16 (a) Informant John Gaston Son
(b) Address 265 S.Robinson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-46 (month) (day) (year)
(c) Cemetery or crematory St.Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 S. Ann st

19 (a) SEP 5 - 1946 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4th 1946, at 3.45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 19 1946 to Sept 4 1946, and that I last saw h[illegible] alive on Aug 19 1946

Immediate cause of death: Hypostatic pneumonia
Duration: 10 days
Due to: Cerebral Arterio-sclerosis
Duration: 7 yrs
Due to:
Other Conditions: Cancer of colon
Duration: ?
(Relation of pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J Feuglo M. D.
Address 700 N Patterson Park Ave Date signed 9/4/46

839

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G43441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE ST
(c) Hospital or institution: ST JOSEPH'S HOSP. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 68

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BAL. CY
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 S. CURLEY. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. OEST

3 (b) If veteran, name war: None
3 (c) Social Security Account No. ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WID.

6 (b) Name of husband or wife: Amelia M. Oest
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1/11/78

8. AGE: Years 68 | Months 8 | Days 3 | If less than one day: hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation BUTCHER *Retired
11. Industry or business Folvus

FATHER
12. Name --
13. Birthplace

MOTHER
14. Maiden Name --
15. Birthplace

16 (a) Informant Mr. E. Wallace Oest
(b) Address 16 S. Curley St.

17 (a) Lor Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons,
(b) Address North & Pa. Aves.

19 (a) SEP 5 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1946, at 5 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19__ to 19__, and that I last saw h__ alive on 19__.

Immediate cause of death: CARDIO RESP. FAILURE — Duration

Due to CARCINOMA OF STOMACH

Due to PER. VIS ADHESIONS

Other Conditions INT. OBSTRUCT HYPOSTATIC PNEUMONIA

If (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature John B Wells
Address Shdon Hosp Date signed 9-4-46

×

G43442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

G43442 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 St. Paul St.
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE Briggs

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Jeanette Briggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	29	hr. min.

9. Birthplace: Horton, Kansas (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: William M. Briggs
13. Birthplace: Jamison, Mo.

MOTHER
14. Maiden Name: Ida May Von Bulhaiser
15. Birthplace: Jamison, Mo.

16 (a) Informant: The Millard, Son & Raper Co.
(b) Address: Carnegie at E. 105th St. Cleveland, Ohio

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/5/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Crematory
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 5 - 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1946 9 15 a. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Subarachnoid hemorrhage

Due to: Arteriosclerosis Hypertension

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/3/46

VS 151

G43143 — BALTIMORE CITY HEALTH DEPARTMENT — G43143 Registered No.

CERTIFICATE OF DEATH 1939

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 3110 Foster Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Foster Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilly K Bowers

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
--	--	F	W	Widowed

6 (b) Name of husband or wife Robert E. Lee Bowers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1864

8. AGE: Years	Months	Days	If less than one day
82	6	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name William Hodge
13. Birthplace -

MOTHER
14. Maiden Name Rachel Shipley
15. Birthplace -

16 (a) Informant Mr. Robert L. Bowers
(b) Address 3110 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 5 - 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1946, at 2.37 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Subrieski M.D. Medical Examiner.
Date signed 9/7/46

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. B43144

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Westerwald Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** GEORGE A. SCHNEIDER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-03-3130

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. George A. Schneider 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1888

8. AGE: Years 57 | Months 9 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baltimore Sun-Linotype operator

11. Industry or business Business

FATHER
12. Name Mr. George Schneider
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Koehring
15. Birthplace Germany

16 (a) Informant Hospital Record
(b) Address 33rd + Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 189

SEP 5 - 1946

Huntington Memorial Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1946, at 5 12/1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1946, to Sept. 4 1946, and that I last saw him alive on Sept 4 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertensive Cardio-vascular disease

Due to:

Other Conditions: Rt. indirect inguinal hernia. Multiple lipomata on arms (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Guide

23. Signature A. V. Lunde, M.D.
Address Union Memorial Hospital Date signed 9/4/46 M. D.

G43445 BC# G 53572

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 159

G43445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Lorraine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/46

8. AGE: Years | Months | Days: 26 | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Chas. E. Doyle,
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mildred Ewing,
15. Birthplace Virginia.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore.
Location North Ave.

18 (a) Funeral director John J. Connelly
(b) Address 419 Eastern Ave. Essex 21.

19 Date received SEP 5 1946 (b) Registrar [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1946 at 7:25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 21 1946 to Sept 4 1946 and that I last saw h[illegible] alive on Sept 4 1946

Immediate cause of death: Septicemia — Duration: 2 days

Due to osteomyelitis, left tibia — Duration: 2 days

Due to

Other Conditions: Prematurity (7½ mos pregnancy)
(Include pregnancy within 3 months of death)

Date of operation 8/21/46

Major findings of operation: MS elevated from left tibia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Denham J. Logan M. D.
Address John Hopkins Hospital Date signed Sept 5 1946

X

G43446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1186a

G43446 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lincoln Madison
(c) Hospital or institution Md. Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo. 25 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Lakeside Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Seitzman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry H. Seitzman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec 3 1864

8. AGE: Years 81 | Months 9 | Days 0 | If less than one day — hr. — min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER
12. Name: Fredk. Covell
13. Birthplace: Germany

MOTHER
14. Maiden Name: not known
15. Birthplace: Germany

16 (a) Informant: Mrs. J. St. Frueh (daughter)
(b) Address: 509 Lakeside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 5-46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore

18 (a) Funeral director: Stewart Morgue Co.
(b) Address: 108 W. Mosher Ave.

19 (a) SEP 5 — 1946 (Date received by registrar) Huntington Hill (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1946, at 1:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1938 to Sept 3 1946, and that I last saw h[illegible] alive on Sept 3 1946.

Immediate cause of death: Congestive Heart Failure — Duration: 2 months and 25 days
Due to: General Debility
Due to: Inactivity following Fractured Left Humerus.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No.

22. If death was due to external causes, fill in the following: 9/2
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence June 8, 1938 at A. M
(c) Where did injury occur? 509 Lakeside Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? [illegible]
(e) Means of injury: Fell at home on floor
23. Signature: [illegible] M.D.
Address: Md. General Hospital Date signed: 9/4/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

Geo. L. Marshall MD Cor. Coroner

G43447 BCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

75262 ✓ 1820

G43447

Registered No. .....

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26
(c) Hospital or institution:
Rodeman Way - Armistead Gardens
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore - Armistead Gardens
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1022 - Spangler Way (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Timothy Blake

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7/20/41

8. AGE: Years	Months	Days	If less than one day
	1	14	..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Bernard B. Blake
13. Birthplace Wilmington Del

MOTHER
14. Maiden Name Ida Reckard
15. Birthplace Md

16 (a) Informant Bernard B. Blake
(b) Address 1022 Spangler Way

17 (a) Burial (b) Date thereof Sept 5th 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morelands
Location Taylor Ave

18 (a) Funeral director Lee G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) ..... (Date filed by registrar) (b) ..... (Signature)

SEP 5 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1946, at 10 45 a. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation
Asphyxiation.
Due to Probable accidental suffocation.
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/4/46 at 7 45 a. M.
(b) Where did injury occur? 1022 - Spangler Way - Armistead
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocation - Clothes

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed Sept. 4, 1946

G43148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121B

G43148
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St 26-11
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 da
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 S. Bouldin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Phillip Sinclair

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-7429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/27

8. AGE: Years	Months	Days	If less than one day
19	0	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Mail Clerk
11. Industry or business May Co.

FATHER
12. Name John H. Sinclair
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lena Schmidt
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 814 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 SEP 5 1946 (Date received by local registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1946 at 1:34 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 9-3 1946 and that I last saw h. alive on 9-3 1946

Immediate cause of death Uremia — Duration

Due to Chronic Glomerulo Nephritis

Due to Right

Other Conditions Congenital Absence Left Kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cohen
Address South Balt. Gen. Date signed 9/3/46

Huntington Williams M.D.

X

G43449 — BALTIMORE CITY HEALTH DEPARTMENT — G43449

CERTIFICATE OF DEATH 46 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Broadway
(c) Hospital or institution: Univ. Hospital 9 W.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
5 City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Ellerslie Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen M. Kaufmann

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Joseph F.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct. 29 1895

8. AGE: Years	Months	Days	If less than one day
50	10	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles W. Aylsworth
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ellen Foster
15. Birthplace Baltimore Md.

16 (a) Informant Joseph F. Kaufmann
(b) Address 3116 Ellerslie Ave.

17 (a) General (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)
(c) Cemetery or crematory H. Redeemer
Location Belair Rd.

18 (a) Funeral director H. W. F. Dippold Sons
(b) Address 2118 Belair Rd.

19 (a) SEP 5 - 1946 (Must fee'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1946 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3/46 8:30 P.M. to 9/3/46 Death and that I last saw h[illegible] alive on 9/3 1946

Immediate cause of death Acute Cardiac Insufficiency 2 Shock — Duration

Due to Probable Ca

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Kaufmann
Address 3116 Ellerslie Ave. Date signed 9/5/46

VS 150

G43450 BALTIMORE CITY HEALTH DEPARTMENT X G43450
CERTIFICATE OF DEATH ✓ 58 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore. 6. (If outside city or town limits, write RURAL and give town)
(d) Street No. Hazelwood & Westwood ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Myrtle L. Bauer (or) Myrtle Lillian Bauer ✓

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 217-18-3681

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife John D.
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Aug 18, 1904

8. AGE: Years	Months	Days	If less than one day
42		16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name George A. Callender
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Lillie Melchoir
15. Birthplace Balto. County Md.

16 (a) Informant: John D. Bauer
(b) Address Hazelwood & Westwood Aves.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory H. Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Oppelt & Sons
(b) Address 7110 Belair Rd.

19 (a) (Date rec'd by registrar) Huntington Williams

SEP 9 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946 at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28/46 19 to 9.4.46 19 and that I last saw h[illegible] alive on 9.3.46 19

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Chronic Valvular disease of Heart	
Due to Rheumatic fever	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 9/7/46

X

H. D. B. 1939-0

643451

HEALTH DEPARTMENT—CITY OF BALTIMORE

643451

CERTIFICATE OF DEATH 90 B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Shields Place St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Virginia Jefferson

(a) Residence: No. 1514 Shields Place St., 14-2 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	Colored	Married

6. If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew E. Jefferson

7. DATE OF BIRTH (month, day, year) 1880

8. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Laundries

10. Date deceased last worked at this occupation (month and year) April 1946

11. Total time (years) spent in this occupation -

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME Hal Knauss

14. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Andrew Jefferson

(Address) 1514 Shields Pl

18. BURIAL, CREMATION, OR REMOVAL

Place Burial Mt Auburn Date 9/7 1946

19. UNDERTAKER Geo. H. Kelson

(Address) 1303 Pennsylvania Ave.

20. FILED SEP 5 - 1946 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 4 1946

22. I HEREBY CERTIFY, That I attended deceased from May 1 1946 to Sept 4 1946

I last saw h Dec alive on Sept 3 1946 Death is said to have occurred on the date stated above, at 4:30 p.m.

The principal cause of death and related causes of importance were as follows:

Acute Pericarditis — Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If of death?

(Signed) Lily Stewart M. D.

(Address) 632 W Franklin St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

643452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 643452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 Seamon ave.
(c) ~~Hospital or institution~~ Home 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore (Cherry Hill) 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Seamon Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Orea Jackson

3 (b) **If veteran, name war** No

3 (c) **Social Security Account No.** None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Clara Jackson
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1894

8. AGE: Years	Months	Days	If less than one day
52	6	11	? hr. ? min.

9. Birthplace Woodruff, S. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business ——

FATHER
12. Name Wallace Jackson
13. Birthplace S.C. ?

MOTHER
14. Maiden Name Harriet Higgins
15. Birthplace S.C. ?

16 (a) Informant Mrs Clara Jackson
(b) Address 2916 Seamon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Wes. H. Kelson
(b) Address 1303 Presstman St

19 (a) —— (b) ——
(Date rec'd by registrar) Registrar

SEP 5 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Sept. 3, 1946, at 8:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1946 to Sept. 3, 1946 and that I last saw h[illegible] alive on August 29, 1946.

Immediate cause of death Pneumonia — Duration Not Known

Due to Acute Infection

Due to Diabetes

Other Conditions Diabetes

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations ——
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Jerry L. Luck, M.D.
Address 303 Bridgeview Date signed 9/3/46

X

643453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

643453 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry Matthews
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Mal.	col	Widow

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Amanda
15. Birthplace

16 (a) Informant Rev John Hammond
(b) Address 1345 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Wm. H. Kehoe
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams MD

SEP 5 – 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2- 1946; at 1 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1946 to 9-2- 1946 and that I last saw h[illegible] alive on 9/1 1946

Immediate cause of death

	Duration
Chronic Cardio Vascular Renal Disease,	6 mos.
Due to Hypostatic Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address Coon Rapids Iowa 9/6/46

G43454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43454
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 18-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Franklin St
(if rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Mosley

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife Millie Mosley
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 11/14/72

8. AGE: Years	Months	Days	If less than one day
73 7 4	9	17	hr. min.

9. Birthplace Newbern [redacted] N.C.
(Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Charles Mosley
13. Birthplace N.C.

MOTHER
14. Maiden Name Caroline Fonville
15. Birthplace N.C.

16 (a) Informant Millie Mosley
(b) Address 1206 Franklin St.

17 (a) Burial (b) Date thereof 9-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary cem.
Location Anne Arundel County

18 (a) Funeral director Byron & Mamie Wright
(b) Address 721 Ausmith St.

19 (a) (b) Washington Williams, M.D.
(Date rec'd by registrar) Registrar

SEP 5 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1946, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1946 to 9-1 1946 and that I last saw him alive on 9-1 1946.

Immediate cause of death: 1. Arteriosclerotic Ht. disease 2. Essential Hypertension — Duration 5-6 Mo. Sa-hist.
Due to
Due to
Other Conditions Congestive Ht. Failure
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Provident Hospital Date signed 9/3/46
M.D.

X

G43455 BC# F46981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170C

G43455 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 15 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Violet Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Alvin Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 29 1942

8. AGE: Years 4 | Months 5 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lester Klein
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Zelda Pritzker
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lester Klein
(b) Address 2912 Violet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-46 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Law

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) (b) Hunting Registrar
SEP 5 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1946 at 2 40 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture and dislocation of 3rd cervical vertebrae, fractured clavicle, ribs and neck of femur

Other Conditions Brush burns, bruises and abrasion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-4-46 — 12 15 P. M. 15/2
(b) Where did injury occur? In front of 2915 Violet Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Thomsen M.D.
Medical Examiner.
Date signed 9-4-46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G43456 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Union 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and name town)
(d) Street No. 705 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maurice Merson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cecelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Showman

11. Industry or business

FATHER 12. Name Jacob

13. Birthplace Russia

MOTHER 14. Maiden Name Clara

15. Birthplace Russia

16 (a) Informant Cecelia Merson

(b) Address 705 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-46 (month) (day) (year)

(c) Cemetery or crematory Lebanon Cem

Location Queens, N. Y.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1619 E Balto St

19 (a) SEP 5 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1946, at 5 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Sept 4 1946 and that I last saw h[illegible] alive on Sept 4 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of lung	2½ months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel D. Gabow

Address Union Hosp Date signed 9/6/46

VS 150

613-31

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1176

Registered No. 93457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Jacob - I Rosenfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wayer

13. Birthplace Bannie Russia

MOTHER 14. Maiden Name Bannie

15. Birthplace Russia

16 (a) Informant Lillian Rosenfield

(b) Address 3712 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-46 (month) (day) (year)

(c) Cemetery or crematory Beth Tefloh

Location Woodsdale Md

18 (a) Funeral director Jack Lewis Inc

(b) Address 2180 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946, at 6:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1946, to Sept 5 1946 and that I last saw h[illegible] alive on Sept. 5 1946.

Immediate cause of death Gastro intestinal hemorrhage — Duration 14 years

Due to Chronic ulcer of duodenum

Due to

Other Conditions Arteriosclerosis, Bronchopneumonia, Kaposi's disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Heinz Blissinger M.D. M. D.

Address Sinai Hospital Date signed 9/6/46

VS 150

G43458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G43458 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4 -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 770 Sierra Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13/1891

8. AGE: Years 54 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Steven Perkins
13. Birthplace Md.

MOTHER 14. Maiden Name Annie L. Walker
15. Birthplace Md

16 (a) Informant Mary A. Long
(b) Address 1710 Eastlane Ave Govans Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Gray O. Wilson
(b) Address 1000 Druid Park Ave

19 (a) SEP 5 1946 Huntington-Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1946, at 1:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 9-2-46

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43459 TN.

BALTIMORE CITY HEALTH DEPARTMENT

102898 **CERTIFICATE OF DEATH** 130

Registered No. G43359

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magdeleene Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd 1909

8. AGE: Years	Months	Days	If less than one day
37	2	0	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lee Cale
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6/46 (Month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland, Md.

18 (a) Funeral director Harry F. Wintse
(b) Address 4101 Edmondson Ave

19 (a) SEP 5 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2nd 1946, at 12.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946 to Sept. 2nd 1946 and that I last saw her alive on Sept. 2nd 1946

Immediate cause of death Pulmonary Tbc for 6 days. — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A.S. Hart, M.D.
Address Balto City Hosp Date signed 9/3/46

VS 150

G43460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. G43460

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 S. Gilmer St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 → 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Gilmer St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burkard J. Jacob
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-10-6787
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Late Catherine L. Jacob
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 20, 1896.
8. AGE: Years 50 Months 2 Days 12 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Koester Bakery
FATHER 12. Name August Jacob
13. Birthplace Germany
MOTHER 14. Maiden Name Unknown
15. Birthplace Germany
16 (a) Informant Louis B. Jacob
(b) Address 305 S. Gilmer St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6/46. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.
18 (a) Funeral director Harry A. Winkler
(b) Address 4101 Edmondson Ave.
19 (a) Date received by local registrar 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1946, at 10:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Sept 2 1946
and that I last saw him alive on Sept 2 1946

Immediate cause of death	Duration
Acute Pulmonary Oedema	1 Hour
Due to Chronic myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nathan Racusin
Address 206 S. Gilmer St. Date signed M. 9 D. 3 1946

VS 150

C 13461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered C 13461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 N Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife David W. Saunders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1888

8. AGE: Years 58 | Months - | Days 22 | If less than one day ___ hr. ___ min.

9. Birthplace Selma N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles D Butler
13. Birthplace Selma N. C.

MOTHER
14. Maiden Name Susan -
15. Birthplace Selma N.C.

16 (a) Informant Jessie Smith
(b) Address 31 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Wm. Katie R. Gilliam
(b) Address 322 W. Lanvale St

19 (a) SEP 5 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Sept 1946, at 9:25 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William T. Gilfeather M.D.
Medical Examiner.
Date signed 3 Sept 46

VS 181

IMPORTANT, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G43462

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THEODOSIA GUILLETTE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Edward P. Guillette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1871

8. AGE: Years	Months	Days	If less than one day
75	5	28	hr. min.

9. Birthplace Accomac, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Watson
13. Birthplace Accomac Co., Va.

MOTHER
14. Maiden Name Harriet Byrd
15. Birthplace Accomac Co., Va.

16 (a) Informant Mr. E. Page Guillette
(b) Address 5601 Woodcrest Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)
(c) Cemetery or crematory
Location Temperanceville, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
(c) Huntington Williams, M.D.
SEP 5 - 1946 (Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1946 at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-1946 to 9-3-1946 and that I last saw h[illegible] alive on Sept 3 1946

Immediate cause of death: Generalized metastasis — Duration 1 yr.
Due to melanoma — approx 2 yrs.
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Theodore Bass, M.D.
Address 817 Med. Arts Bldg Date signed 9-4-46
Baltimore, 1, Md

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G43463 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Northern Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Estella A. Rooney

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	M

6 (b) Name of husband or wife James P Rooney
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1885

8. AGE: Years	Months	Days	If less than one day
61	6	26	hr. min.

9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Frank Oates
13. Birthplace —

MOTHER
14. Maiden Name Honora Dempsey
15. Birthplace —

16 (a) Informant James P. Rooney
(b) Address 2909 Northern Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) SEP 5 1946 (Date received by registrar) (b) Registrar
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1946, at 5 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h Ed alive on 9-5 1946.

Immediate cause of death	Duration
Resp. failure	
Due to Pulmonary edema	
Due to cardiac failure	
Other Conditions chronic cholecystitis	
Cholecystectomy 8-29-46 (Include pregnancy within three months of death)	
Date of operation 8-29-46	
Major findings of operation: cholecystitis & cholelithiasis	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address Calvert + Saratoga Date signed 9-5-46

643464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

643464 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 Grindon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Grindon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B Koehler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife George Koehler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1883

8. AGE: Years	Months	Days	If less than one day
63	1	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Jacob Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Morgenwig
15. Birthplace Germany

16 (a) Informant George Koehler
(b) Address 2806 Grindon Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Sept 6/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md
18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 5 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 19 12:40 am M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Aug 1946 and that I last saw her alive on Aug 29 1946

Immediate cause of death Carcinoma of Rectum with metastasis and anemia. Duration

Due to

Due to

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation Dec 1945

Major findings of operation: Carcinoma of Rectum with

of autopsy: metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd Date signed 9-3-46

Huntington Williams, M.D.
Registrar

X

643465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

643465 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6221 Shipview Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6221 Shipway Shipview
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ernst

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John C. Ernst
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 14 1867

8. AGE: Years	Months	Days	If less than one day
79	3	14	hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER	12. Name John Geising
	13. Birthplace Germany
MOTHER	14. Maiden Name
	15. Birthplace Germany

16 (a) Informant John C. Welch
(b) Address 6221 S Shipview Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-46 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Catonsville Md

18 (a) Funeral director Lloyd Funeral Home
(b) Address 2008 Orleans St
Remington for Williams, 1811

19 (d) SEP 5 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1946, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to Sept 3 1946, and that I last saw alive on Sept 3 1946.

Immediate cause of death	Duration
Carcinoma of uterus & hepatic metastasis	6-12-45
Due to	
Due to None	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature
Address 842 S Exeter Date signed 9-4-46 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G43466 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St 23
(c) Hospital or institution: Sa Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 41 E. Randall St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Milton J Harvey
3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-03-0275

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ada E. Harvey (Nee Wise)
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1884

8. AGE: Years 62 | Months 9 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Journeyman Plumber
11. Industry or business A J Bayse Plumber

FATHER 12. Name James E. Harvey
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Laura V. Ward
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Ada E. Harvey (Wife)
(b) Address 41 E. Randall St, Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedarhill Cem
Location Balto. Co., Md.

18 (a) Funeral director A. Bernard Evans
(b) Address 4009 Eldorado Ave Balto

19 (a) ____ (b) ____ (Date received by registrar) Registrar

SEP. 5 - 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 3 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1946 to 9-3 1946 and that I last saw him alive on 9-3 1946

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operations: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____
(e) Means of injury ____

23. Signature Herbert W. Crandell M.D.
Address 30 Balto Gen. Hosp Date signed 9-3-46

X

G43467. BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43467.

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2. days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Bowden, Willoby Scott

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-1181

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1906

8. AGE: Years	Months	Days	If less than one day
40	6	15	hr. min.

9. Birthplace Rocky Mt. NC. (Town, county, and state)
10. Usual Occupation AB seaman
11. Industry or business Seafarer

FATHER
12. Name Rufus Bowden
13. Birthplace NC

MOTHER
14. Maiden Name Julia Mitchell
15. Birthplace NC

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-46 (month) (day) (year)
(c) Cemetery or crematory Family burial grounds Location Springhope North Carolina

18 (a) Funeral director Taylor McBrooks
(b) Address Sparks, Md.

19 (a) (Registrar's signature) (b) Registrar

SEP 5 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1946 at 1:58 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1946 to Sept. 5 1946. and that I last saw h im alive on Sept. 5 1946.

Immediate cause of death Coronary sclerosis with occlusion and myocardial infarction — Duration UNKNOWN

Due to (2) Infarction, pulmonary, ~~Duration~~ multiple — SEVERAL DAYS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 9/5/46 M. D.

Huntington Williams, M.D.

X

G43468 BALTIMORE CITY HEALTH DEPARTMENT G43468

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-9
(b) Street address Monument H
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BENJAMIN A. COHEN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dupes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Riga (Town, county, and state)

10. Usual Occupation Cap maker

11. Industry or business

FATHER 12. Name Daniel

13. Birthplace Riga

MOTHER 14. Maiden Name Lehren

15. Birthplace Riga

16 (a) Informant Harry Cohen

(b) Address 3016 Rosalind Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-46 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Park Rd & Bancroft Lane

18 (a) Funeral director Jerk Levy Inc

(b) Address 1439 E. Balto St

19 (a) (Date received by Registrar) (b) Registrar

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5-46 19 at 2 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1946, to 9-5 1946, and that I last saw him alive on 9-5 1946.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B. Hyman M. D.

Address Sinai Hospital Date signed 9-7-46

VS 150

X

G43469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 V

G43469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 N. Carrollton Ave
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME EMILY V. COOPER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife George
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 11/20/1884

8. AGE: Years	Months	Days	If less than one day
61	9	13	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Charles Chapman
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Alice Dorsey
15. Birthplace Baltimore, Md.

16 (a) Informant Charles G. Cooper (Son)
(b) Address 510-512 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Baltimore County, Md.

18 (a) Funeral director H. Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) Filed SEP 6 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/1946 19 , at 4:01 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1946 to Sept. 3 1946 and that I last saw h[illegible] alive on Sept. 2 1946.

Immediate cause of death	Duration
Cerebral Hemmorhage	6 days.
Due to Hypertensive Heart disease	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Wallis Shearer M. D.
Address 201 N. Carey St. Date signed 9/7/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43470 — BALTIMORE CITY HEALTH DEPARTMENT — G43470 Registered No.

CERTIFICATE OF DEATH

52a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: Dr. McKenna's Memorial Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADA V. LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1888

8. AGE: Years	Months	Days	If less than one day
58	4	25 23	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Dress Shop
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Miss Alice T. Smith
(b) Address 3013 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by local registrar) (b) Huntington Williams, M.D.

SEP 5 - 1946

Vs 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Sept. 4, 1946 at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1946 to Sept. 3 1946, and that I last saw h[illegible] alive on Sept. 3 1946

Immediate cause of death	Duration
Generalized metastasis.	
Due to Hypernephroma	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/20/45

Major findings of operation: Metastases of L. humerus

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Mungavin Jr. M.D. Address 3301 N. Charles St. Date signed 9/4/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G43372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 Brambleton Rd.
(c) Hospital or institution:

27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Brambleton Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD MARION BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Lee Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1861

8. AGE: Years	Months	Days	If less than one day
84	9	6	hr. min.

9. Birthplace New York.
(Town, county, and state)
10. Usual Occupation U. S. Customs Inspector
11. Industry or business U. S. Government

FATHER
12. Name David Brown
13. Birthplace New York

MOTHER
14. Maiden Name Hine
15. Birthplace New York

16 (a) Informant Mr. Marion L. Brown, son
(b) Address 2430 Brambleton Rd. 7

17 (a) Burial (b) Date thereof 9/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Centre Cem.
Location Forest Hill, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) SEP 6 - 1946 (b) Huntington Whitehead, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1946 at 4:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1946 to Sept 5 1946 and that I last saw h. alive on Sept. 5 1946

Immediate cause of death: Myocardial Chronic — Duration 1yrs

Due to

Due to

Other Conditions: Esophageal diverticulum — 20 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherwood R. Hunt M. D.
Address 2601 Maunsell Ave Date signed 9/5/46

Wants

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G43472 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 N. Fremont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 N. Fremont ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Gallamore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Joseph Gallamore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1886

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Levin A. Banthem
13. Birthplace md

MOTHER
14. Maiden Name Annie Jackson
15. Birthplace Md

16 (a) Informant Joseph Gallamore
(b) Address 525 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Pratt St

19 (a) Registered by Huntington Williams, M.D. Registrar

SEP 6 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1946 at 5:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 27 1946 to Sept 5 1946 and that I last saw him alive on Sept 5 1946

Immediate cause of death

(a) Cerebral Hemorrhage 7 days
Due to Melanosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 9/5 1946

G43473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G43473
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 942 Greenmount Ave. D.U.A.
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 942 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patsy Lancaster

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Gloster Co. Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Charles Lancaster
13. Birthplace Va

MOTHER 14. Maiden Name Patsy Jones
15. Birthplace Va

16 (a) Informant James Yates
(b) Address 942 Greenmount Ave

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Baltimore Md

18 (a) Funeral director Mr Thomas A Hemsley
(b) Address 538 W Biddle St

19 (a) SEP 6 1946
(Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Sept. 1946, at 11:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Renal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kamman Jr. M.D.
Medical Examiner.
Date signed 2 Sept. 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43474 — BALTIMORE CITY HEALTH DEPARTMENT — G43474 Registered No.

CERTIFICATE OF DEATH

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 Annapolis Rd
(c) Hospital or institution: 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Ludwig

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy E. Ludwig
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.): March 27- 1892

8. AGE: Years 54 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Retired Fireman
11. Industry or business: Balto Fire Dept

FATHER
12. Name: Julius Ludwig
13. Birthplace: Germany

MOTHER
14. Maiden Name: Matilda Baunier
15. Birthplace: Balto Md

16 (a) Informant: Dorothy E. Ludwig
(b) Address: 2325 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 7- 1946 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Balto Md

18 (a) Funeral director: Watt C+ B.M. Walters
(b) Address: Fath + Sticker Sts

19 (a) (b) Registrar

SEP 6 1946
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 1946, at 6 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 3 1946 and that I last saw h[illegible] alive on Sept 3 1946.

Immediate cause of death
Coronary Thrombosis — Duration: 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Paul Schuyler
Address: 1901 Arnpell Date signed: 9/7/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G433475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G433475 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 Mt Olivet Lane
(c) Hospital or institution: 20-6.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Mt. Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Atkinson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-13-1882.

8. AGE: Years	Months	Days	If less than one day
64 63	2	19	— hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Moses O. Atkinson
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Henrietta Mund
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Mazie E. Saylor
(b) Address 318 Mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 Sept. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director C. B. Wilbert's Son
(b) Address 1300 Eutaw Place - 17

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 6 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Sept. 1946. at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1946, to 2 Sept 1946, and that I last saw h[illegible] alive on 2 Sept 1946.

Immediate cause of death: Pulmonary Oedema, chronic — Duration 6 weeks

Due to Chronic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen

Address 206 S. Gilmor St Date signed 9-5-46

X

G43476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43476 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Nicoll Ave
(c) Hospital or institution: 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Nicoll Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Sinnott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife John Sinnott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 - 1865

8. AGE: Years	Months	Days	If less than one day
81	3 4	29	hr. min.

9. Birthplace Balto Co Md (Town, county, and state)
10. Usual Occupation H. Duties
11. Industry or business

FATHER
12. Name Mulgrew and Fusher
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Feaney
15. Birthplace Ireland

16 (a) Informant Mrs P Brockmon
(b) Address 604 Nicoll Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory St Mary's Govans
Location Homelands Park

18 (a) Funeral director J. J. Raley & Sons
(b) Address 618 Light St.

19 (a) Date received by registrar SEP 8 1946 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/46 19 , at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1946 to Sept 7 1946 and that I last saw h cc alive on Sept 5 1946

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease — Duration 10 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. D. Thomas M. D.
Address 11 E. Chase St Date signed 9-8-46

G13477.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G13477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN PARKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Georgia Parker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace W. Va. Co. Md-
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden Name unknown

15. Birthplace "

16 (a) Informant John Major

(b) Address 1010 Warner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Braddish Ave

19 (a) Filed SEP 6 1946 (b) Registrar Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/46 19 , at 8:10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John D. Dewitt M.D.
Medical Examiner.

Date signed 9/3/46

G43378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

G43378
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 5-1
(a) Baltimore City, Maryland
(b) Street address 1810 N. Spring St.
(c) Hospital or institution:
Pronounced dead on arrival at Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 May St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HASKELL BOYD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Hollyaville S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Willie Boyd.
13. Birthplace Hollyville S. C.

MOTHER
14. Maiden Name Lottie Bryant
15. Birthplace Hollyville, S. C.

16 (a) Informant Mathew Moore
(b) Address 1303 may St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Boyers Cem
Location Dorchester, S. C.

18 (a) Funeral director Thos. O. Wilson
(b) Address 1000 Bentley ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 6 - 1946

vs 1y

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1946, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion with
Myocardial infaretion

Due to Syphilitic aortitis

Other Conditions Syphilitic aortic valvulitis
Dilatation of heart.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed Sept. 4, 1946

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13279 ✓ G13279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Carroll
(a) State Md. (b) County Baltimore
(c) City or town Westminster - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Pennsy Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Amanda Ruthrauff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife Charles Ruthrauff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1862

8. AGE: Years	Months	Days	If less than one day
83	9	30 29	hr. min.

9. Birthplace Williamsport, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. Edna Dutterer
(b) Address Westminster, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 6 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5th 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-46 19 , to 9-5-46 19 , and that I last saw h[illegible] alive on 9-5-46 19

Immediate cause of death	Duration
Cardio circulatory failure	
Due to	
Due to Fractured right hip	
Other Conditions Diabetes mellitus Hemiplegia (right) (Include pregnancy within 3 months of death)	
Date of operation None	
Major findings of operation:	
of autopsy: —	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Sept. 1st 1946 at 2 - M
(c) Where did injury occur? Westminster (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fell to floor from wheel chair
(f) Signature John F. Noguera M.D.
Address Md. Osteo. Hospital Date signed 9/6/46

For Phillip J. Hefferd, by Howard J. Mercer, M. D. X

G43480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G43480 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 28-4
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 MINUTES

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Edmonson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Reis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary A. Lavezza
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29-1891

8. AGE: Years	Months	Days	If less than one day
55	2	6	hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business

FATHER
12. Name William Reis
13. Birthplace Balto Md

MOTHER
14. Maiden Name Emma Heinz
15. Birthplace

16 (a) Informant Wife Mary Lavezza Reis
(b) Address 516 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Balto St

19 (a) (Date rec'd by registrar) (b)

SEP 6 - 1946

Huntington Williams, M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 19 , at 11:46 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death Coronary Occlusion

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Davis, Medical Examiner
Address Date signed 9/4/46

X

G43:81

49996T

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43:81

CERTIFICATE OF DEATH 107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford.
(c) City or town Darlington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Forelyn Willing Peters. ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mable.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-86

8. AGE: Years	Months	Days	If less than one day
60	2	14	hr. min.

9. Birthplace Wyoming. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Thomas Peters
13. Birthplace Pa.

MOTHER 14. Maiden Name Minnie Macomb
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept 8, 1946 (month) (day) (year)
(c) Cemetery Harmony Cem
Location Harford Co. Md.

18 (a) Funeral director H. B. Bailey
(b) Address Darlington Md.

19 SEP 6 1946 Darlington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept- 6 1946 at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug- 30 1946 to Sept 6 1946 and that I last saw him alive on Sept- 6 1946

Immediate cause of death	Duration
(a) BRONCHO PNEUMONIA	10 DAYS
Due to (b) EMPHYSEMA	
Due to (c) BRONCHIAL ASTHMA, CHRONIC	11 YRS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Minnie B Whitehead M.D.
Address JHH Date signed 5 Sept 46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G43382 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4307 Elderon Ave.
(c) Hospital or institution:
28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Elderon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matthew J. McDermott

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Annie Delaney
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan. 3 1872

8. AGE: Years	Months	Days	If less than one day
74	8	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James McDermott
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Neville
15. Birthplace Baltimore

16 (a) Informant Mrs. Annie McDermott
(b) Address 4307 Elderon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Loudon Pk. Balto. Md.

18 (a) Funeral director Martin Tighe & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd) (b) (Registrar) Registrar

SEP 6 - 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1946 to Sept 5 1946, and that I last saw h[illegible] alive on Sept 4 1946.

Immediate cause of death Left Hemiplegia — Duration 3 da.
Due to Cer. - Nephritis.
Due to Hypertrophy Prostate Gland.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. E. Shannon M.D.
Address 720 Medical Arts Bldg. Date signed 9/7/46 M. D.

X

G43483 BC.9-56053 BALTIMORE CITY HEALTH DEPARTMENT G43483
CERTIFICATE OF DEATH 1600 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp. 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED Newborn
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Laurence Ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Newborn

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/29/46

8. AGE: Years	Months	Days	If less than one day
			11 hr. 41 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Jessie Edward Hood
13. Birthplace N.C.

MOTHER
14. Maiden Name Lenna Bernice Taylor
15. Birthplace Norfolk Va.

16 (a) Informant Leland B. Hood (Mother)
(b) Address 1431 Laurence Ave.

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 5 1946

18 (a) Funeral director
(b) Address Commissioner of Health

19 SEP 6 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Aug 1946, at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Aug 19 46 to 30 Aug 19 46 and that I last saw h. alive on 29 Aug 19 46.

Immediate cause of death Cardio-Resp. failure. — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George L. Lennox, M.D.
Address Univ. Hosp. Date signed 30 Aug 1946

X

G43484 full

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G43484 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23-3
(c) Hospital or institution: West Balt. Genl. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 50 E. Heath St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Reichert II

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/46

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace West Balt. Genl. Hosp. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Reichert
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Lillian Wept
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 5 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 6 1946 (Date received by Registrar) (Huntington Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946, at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946, to Sept 4 1946, and that I last saw [illegible] alive on Sept 4 1946.

Immediate cause of death — Duration
CHD - respiratory failure
Due to Prematurity - Weakness
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2535 Eutaw Place Date signed 9-5-46

VS 150

G13485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G13485 Registered No.

CMK-103226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2-
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 861 S. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Syez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15-1887

8. AGE: Years	Months	Days	If less than one day
58	10	14	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Syez
13. Birthplace Poland

MOTHER
14. Maiden Name Evie Kirraczoski
15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 6 1946

18 (a) Funeral director Commissioner of Health
(b) Address
SEP 6 1946 Huntington Williams, MD
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1946, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1946 to Aug. 29 1946 and that I last saw him alive on Aug. 29 1946.

Immediate cause of death	Duration
Pulmonary tuberculosis,	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Marcus G. Kessler M. D.
Address City Hospitals Date signed 8/31/46

G43486

JL - 85947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43486

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 12 days 26-12
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. NO Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Harry Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1882

8. AGE: Years	Months	Days	If less than one day
64	6	15	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Walker
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 6 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 6 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1946, at 8:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1944 to Aug. 29 1946, and that I last saw h im alive on Aug. 29 1946

Immediate cause of death	a.	Duration
Bronchopneumonia		
Due to Hypertension & Arteriosclerotic C-V Disease		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Fauber M. D.
Address Balto. City Hosp. Date signed 9-27-46

G43487 BCH G54480 CLIFTON EDWARD SHINABERRY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓159

Registered No. G43487

499142.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-4
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Clayton Court. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Clifton Edward Shinaberry Clifton Edward Shinaberry
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-16-46

8. AGE: Years	Months	Days	If less than one day
		20.	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clifton Edward Shinaberry
13. Birthplace West Virginia

MOTHER
14. Maiden Name Marie Lavern Dyer
15. Birthplace Balto. Md

16 (a) Informant Recnds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (month) 6 (day) 1946 (year)
(c) Cemetery ~~or crematory~~ Holy Cross M.E. Co.
Location Patapsco Highway
18 (a) Funeral director Elizabeth Harle Dec.
(b) Address 115 E. Biddle St. Balto. Md.
1946 SEP 6 Date received by local registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 6 1946 at 5:55 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 16 1946 to Sept - 6 1946 and that I last saw him alive on Sept - 6 1946
Immediate cause of death

	Duration
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert J. Sheldon
Address Date signed 9/6/46

VS 150

G43488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G43488

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-2
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Sargent Street 23 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter William Stierhoff STIERHOFF

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-05-8765

4. Sex: M

5. Color or race: W

6 (a) Single, (Married) widowed, or divorced.

6 (b) Name of husband or wife: Anna Stierhoff

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.) 1/11/86

8. AGE: Years 60 | Months 7 | Days 25 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Straw Hat Maker

11. Industry or business

FATHER
12. Name: John Stierhoff
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Anna Dittmar
15. Birthplace: Balto

16 (a) Informant: Anna M. Stierhoff - wife
(b) Address: 1119 Sargent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 9 1946 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: City

18 (a) Funeral director: Wm. Mrs. John W. Teufel's Son
(b) Address: 801 W. Fayette St.

19 (a) (b) Huntington Williams, M.D.

SEP 6 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5/46 19 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4/46 19 to 9/5/46 19, and that I last saw h alive on 9/5/46 19.

Immediate cause of death	Duration
uremia	
Due to chronic nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: chronic nephritis H.O.P.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. North M.D.
Address Bon Secours Hop. Date signed 9/5

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G43489

10-1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1918

8. AGE: Years 28 | Months 2 | Days | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Brocker
13. Birthplace N.C.

MOTHER
14. Maiden Name Hannah Ford
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory
Location Brooklyn, N.Y.

18 (a) Funeral director Joseph B. Locke & Co.
(b) Address 1304 N. Central Ave.

19 SEP 6 - 1946 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1946 at 1.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1946 to Sept 5 1946 and that I last saw h[illegible] alive on Sept. 5 1946

Immediate cause of death Diabetic acidosis & coma — Duration 12 hours

Due to Diabetes mellitus — 4 years

Due to Acute pancreatitis — 24 hrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: Acute pancreatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Davis
Address Johns Hopkins Hosp. Date signed 9/5/46

VS 150

Dr Camper

G43190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 48 B

G43190 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 12-2
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Barclay St (If rural give location)
(e) Citizen of foreign country? NC (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Tyler
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Fe
5. Color or race: N
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife U. Grant Syler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/63

8. AGE: Years 83 | Months 7 8 | Days 17 14 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Home m. F. (Retired Teacher)
11. Industry or business

MOTHER / FATHER
12. Name Peter Jeffries
13. Birthplace Va.
14. Maiden Name Lucy Campbell
15. Birthplace Va.

16 (a) Informant Lavinia C. Branch
(b) Address 3113 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Joseph L. Locke
(b) Address 1367 W. Central Ave Huntington Williamsa, Md

19 (a) Date received SEP 6 1946 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946 at 8.5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24- 1944 to 9-6- 1946 and that I last saw h. alive on Sept 4 1946

Immediate cause of death: Carcinoma of uterus — Duration 2 yrs

Due to

Due to

Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. J. Camper M. D.
Address 639 N. Carey Date signed 9-6-46

X

G43491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G43491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 5-2
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Low Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Lee Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1915

8. AGE: Years	Months	Days	If less than one day
31	-	24	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Moses Thomas
13. Birthplace Va

MOTHER
14. Maiden Name Maria Lester
15. Birthplace Va

16 (a) Informant Myrtle Brown
(b) Address Potapsco Pk. Brooklyn, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem
Location Balto., Md.

18 (a) Funeral director Joseph B. Lorkin
(b) Address 1303 W. Pratt St

19 (a) SEP 6 - 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1946 at 5 57 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to stab wound of chest involving lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-4-46 at 5:30 A. M.
(b) Where did injury occur? Albemarle & Baltimore Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbing - Sharp Instrument

23. Signature Howard J. Wilkins M.D. Medical Examiner.
Date signed 9-4-46

VS 191

643192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

643192
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes 26-4
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Baltimore~~ Md. (b) County ~~Baltimore~~ Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Steiger Way - 5 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DELLA SCOVERN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Homer E.

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 6-16-1887

8. AGE: Years	Months	Days	If less than one day
59	2	15	20 hr. ___ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harden T. Ellis
13. Birthplace Ky.

MOTHER
14. Maiden Name Marilla Gallion
15. Birthplace Mo.

16 (a) Informant Homer E. Scovern
(b) Address 1129 Steiger Way - City - S

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Lawn
Location East Hampton, L. I., N.Y.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1600 Eutaw Place

SEP 6 1946 (Date received) Huntington Williamsville (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946 at 2.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1946 to Sept 6 1946, and that I last saw h.e.) alive on Sept 6 1946.

Immediate cause of death	Duration
respiratory failure	
Due to carcinoma breast	
Due to metastases abdominal	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K. S. Yankopolus M. D.
Address Agnes Hosp. Date signed Sept 6 1946

K. S. Yankopolus

G43493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√93 D

G43493 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Friederika Pohlmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9 Mar 1862

8. AGE: Years	Months	Days	If less than one day
84	3 5	26	____ hr. ____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name August J. Schneider
13. Birthplace Germany

MOTHER 14. Maiden Name Louisa Niemeyer
15. Birthplace Germany

16 (a) Informant Orlando L. Robinson
(b) Address 2207 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Gilbert Coffee
(b) Address 1219 Pont St

19 (a) SEP 8 1946 (Date rec'd by Registrar) (b) H. Livingston Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Sept 1946, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Sept 1946 to 5 Sept 1946, and that I last saw h[illegible] alive on 5 Sept 1946.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Buschman M.D.
Address Women's Hospital Date signed 5 Sept 46

G43494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/31a

Registered No. G43494

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Dukeland
(c) Hospital or institution Mt Balto Gen Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Williams

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of ~~husband or~~ wife: Emma L. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28th 1855

8. AGE: Years	Months	Days	If less than one day
90	9	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name (Unknown) Williams
13. Birthplace "

MOTHER 14. Maiden Name Elizabeth (Unknown)
15. Birthplace "

16 (a) Informant Albert B. Williams
(b) Address 6031 Guyana Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

SEP (a) 6 - 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 September 1946 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Sept 1946 to 5 Sept 1946 and that I last saw h[im] alive on 5 Sept 1946

Immediate cause of death: Cardio Respiratory Failure — Duration

Due to: Pul. Edema

Due to: Bronchopneumonia and Arteriosclerosis.

Other Conditions: C.V. Renal Dis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: atual

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester A. Walls M.D.
Address Mt Balto Gen Hosp Date signed 9/5/46

G43495 — Gnon, 4136 Park Heights Ave — G43495

BALTIMORE CITY HEALTH DEPARTMENT

League CERTIFICATE OF DEATH ✓ 48 B Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth League LEAGUE

3 (b) If veteran, name war: No | 3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Howard

6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.) Oct 6 (1867)

8. AGE: Years 73 (79) | Months 10 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Rudolph
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Fourthon
15. Birthplace Germany

16 (a) Informant Mrs Walter Dickett
(b) Address 4102 Reisterstown Rd

17 (a) Burial (cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Fulton Dob Inc
(b) Address 1314 E Fort St

19 (a) 9 1946 (Date rec'd by registrar) (b) Burial Permit No. 48 B

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1946 to Sept 4 1946, and that I last saw her alive on Sept 4 1946.

Immediate cause of death: Carcinoma Uterus — Duration: one week

Due to:

Due to:

Other Conditions Age
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Evans
Address 7201 York Rd Date signed 9-5-46

Balto 12 md X

VS 150

G43496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43496 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Dutton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Grace Crescentia Sherwood

3 (b) If veteran, name war: N

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~or wife~~ Harry S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/73

8. AGE: Years	Months	Days	If less than one day
73	4	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Gerard Hausmann

13. Birthplace Germany

MOTHER 14. Maiden Name Maria Mooney

15. Birthplace N. Y.

16 (a) Informant Harry S. Sherwood

(b) Address 9 Dutton Ave. Catonsville Md

17 (a) Burial (Burial, ~~cremation, removal~~) (b) Date thereof 9/7/46 (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 SEP 6 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/46 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2/46 19 to 9/4/46 19, and that I last saw her alive on 9/4/46 19.

Immediate cause of death coronary occlusion — Duration

Due to coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Balaban M.D.

Address Bon Secours Hosp. Date signed 9-4-46

X

G43497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43497 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maynard Parkland
(c) Hospital or institution: West Balto Gen Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 Hayward Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No. 050-16-4255

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	WHITE	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
73 (?)			hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Hospital Records
(b) Address W. Balto General

17 (a) Burial (b) Date thereof Sept 7-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Harry M. Armacost
(b) Address 4204 Ridgewood Ave

19 (a) Sept 6 1946 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 September 1946, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Aug 1946, to 4 Sept 1946 and that I last saw h[illegible] alive on 4 Sept 1946.

Immediate cause of death	Duration
Cardio Resp. Failure	
Due to Cerebral Accident	
Due to Arteriosclerotic C.V. Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Luther A. Smee Jr
Address West Baltimore Date signed 9/5/46 M.D.

Gen Hosp

G43498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √131a

G43498 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Weitzel Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State √Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Weitzel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F. Schwartz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna E. Schwartz 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/5/64

8. AGE: Years	Months	Days	If less than one day
82	5	1	hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Florist

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Edw. Schwartz
(b) Address 2814 Grinden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 9 46 (month) (day) (year)
(c) Cemetery or crematory Immanuel Luth.
Location Balto. Md

18 (a) Funeral director Bosgahm Funeral Home
(b) Address 7401 Belair Rd.

SEP 6 - 1946 (c) Date received by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1946 at 1:42 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Sept. 1946 and that I last saw him alive on Sept. 4 1946.

Immediate cause of death Uraemia — Duration 4 D Hrs.

Due to Arteriosclerotic cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Harry Hearn M. D.
Address 5718 Hughes Rd. Date signed 9-7-46

VS 150

G43499

498697.

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 46B

Registered No. G43499

MARGIN RESERVED FOR BINDING. The... PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write th...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Elizabeth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas H. Tosa.

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-4406

4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Theophine

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 8-19-91

8. AGE: Years 55 | Months - | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Hungary, (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name Peter Tosa.
13. Birthplace Hungary.

MOTHER 14. Maiden Name Maria Ristar
15. Birthplace Hungary.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9th 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director B. E. Harle
(b) Address 1221 W. West St

19 (Date received by registrar) SEP 7 - 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept- 6 1946 at 1.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 9 - 1946 to Sept- 6 1946 and that I last saw h[illegible] alive on Sept- 6 1946.

Immediate cause of death	Duration
Coronic failure	48 hrs
Due to	
Due to	
Other Conditions Carcinoma of stomach + esophagus	

(Include pregnancy within 3 months of death)

Date of operation 31 Aug 46
Major findings of operation: Malignancy - also CA.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Bayne Huggins M.D.
Address Johns Hopkins Hosp. Date signed Sept 7 46

VS 150

043500

BALTIMORE CITY HEALTH DEPARTMENT

ED #106239

CERTIFICATE OF DEATH 1939

Registered No. 043500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 46 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1900

8. AGE: Years	Months	Days	If less than one day
46	5	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name James Hall
	13. Birthplace Maryland
MOTHER	14. Maiden Name Alice Hanna
	15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave

19 Date received by local registrar SEP 7 - 1946 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1946, 10:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 3, 1946 to Sept. 4, 1946, and that I last saw h alive on Sept. 4, 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Edema	
Due to Hypostatic Congestion Cardiovascular Disease	
Other Conditions Renal Insufficiency	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Arteriosclerosis Heart, Chronic Interstitial Nephritis, Pulmonary Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Scarborough M. D.
Address Balto. City Hosp. Date signed 9-8-46

X

G43501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 121

Registered No. G43501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEA
(a) Baltimore Ci ryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 E. 37th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John T O'Toole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Caroline S. O'Toole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22nd 1891

8. AGE: Years	Months	Days	If less than one day
54	10	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Garage Foreman
11. Industry or business Railway Express

FATHER
12. Name John O'Toole
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Lee
15. Birthplace Ireland

16 (a) Informant Caroline S. O'Toole
(b) Address 924 E. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 817 St. Paul St.

SEP 7 1946
(Date rec'd by registrar)

(b) Institution Williamsport, Md.
C. J. Zubrod

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Sept. 1946, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Sept. 1946 to 6 Sept. 1946, and that I last saw him alive on 6 Sept. 1946.

Immediate cause of death: Cardiac failure — Duration

Due to Generalized peritonitis.

Due to

Other Conditions Ruptured appendix

(Include pregnancy within 3 months of death)

Date of operation 6 Sept. 1946

Major findings of operation: Ruptured appendix.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. T. McE. Bonzano M. D.
Address Maryland General Hospital Date signed 6 Sept. 1946

Thomas J. Mannion, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

043502 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V157E

Registered No. 043502

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Hr.25Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore - 23,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brady

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/46

8. AGE: Years	Months	Days	If less than one day
			1 hr. 25 min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harvey John Brady
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Evelyn Longan
15. Birthplace Baltimore Md.

16 (a) Informant Harvey J. Brady
(b) Address 2551 W Hollins St
17 (a) Burial (b) Date thereof 9/7/46
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Anthony J. Doe
(b) Address 1214 S Fond St
19 (Date received) SEP 7 1946 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6-46 19 , at 9:50 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death	Duration
Tetralogy of Fallot	
Due to Cardiac Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature DeMar Laughlin
Address 400 N. Payson St Date signed 9/6/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

643503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A 181

643503 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Middle Rivers
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oakfield Ave. Hilltop Park
Middle River Baltimore Md.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eve Fay Nye

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1945

8. AGE: Years	Months	Days	If less than one day
1	2	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thorn Gilbert Nye
13. Birthplace New York

MOTHER
14. Maiden Name Velma Carter
15. Birthplace Ga.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Buried (b) Date thereof 9 7 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Talbot Road

18 (a) Funeral director Burgunthie
(b) Address 1407 Eastern Ave. Rd Huntingtown Williamsport, Md

19 SEP 7 - 1946 (b) Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1946 at 1:32 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1946 to Sept. 6, 1946
and that I last saw h. er alive on Sept. 6, 1946

Immediate cause of death
Second & Third Degree Burns — Duration 18 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-5-46 at 5:30 P M
(c) Where did injury occur? Oakfield Ave - Middle River Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? House While at work? no
(Specify type of place)
(e) Means of injury Clothing Caught Fire Burned - Burned with gasoline
23. Signature W. Wilbert Hughes
Address Balto City Hosp Date signed 9-6-46 (M. D.)

VS 150

To Be Approved by Medical Examiner
John R. Orvis by Howard J. Weaver, M.D.

G43504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G43504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Echodale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Echodale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES ANDREW SCHAEFER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Feldner Schaefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1875

8. AGE: Years 71 | Months 2 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business Self

FATHER
12. Name John Henry Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Hilgartner
15. Birthplace Germany

16 (a) Informant Mrs. Anna Feldner
(b) Address 2903 Echodale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Rd.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 7 - 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1946 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 Sept. 4 19 and that I last saw him alive on Sept. 4 1946.

Immediate cause of death — Duration

Cerebral-Hemorrage — 3 days
Due to
Arterio-Sclerosis
Due to

Other Conditions Padgetts Disease
Arrested Pulmonery T.B.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. John H. Owens M. D.
Address 22-2 Preston Date signed Sept 6 1946

VS 150

G43505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 112

Registered No. G43505

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 East Eager (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James F Cline

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 231-16-4912

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Margaret Cline nee Ramsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1912

8. AGE: Years	Months	Days	If less than one day
34	5	19	hr. min.

9. Birthplace Lexington Va. (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Contracting Concern

FATHER
12. Name John F. Cline
13. Birthplace Lexington Va

MOTHER
14. Maiden Name Bertie V. Fitzgerald
15. Birthplace Va.

16 (a) Informant Mrs. Margarette E. Cline
(b) Address JOHNS HOPKINS HOSPITAL 604 E Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/46 (month) (day) (year)
(c) Cemetery or crematory Fairfield Cemetery
Location Fairfield, Va.

18 (a) Funeral director Elmer W. Corkhill & Son
(b) Address 924 E. Eager St.

19 SEP 7 1946 Lexington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 6 1946 to Sept 6 1946, and that I last saw him alive on Sept. 6, 1946.

Immediate cause of death	Duration
Status Asthmaticus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip J. Magley M.D.
Address Johns Hopkins Hosp Date signed Sept 6, 46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43506 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G43506

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton & Catonsville Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 S. Prospect Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Craig Timothy Crider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6 1946

8. AGE: Years Months Days 3 days If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William V. Crider, Jr.
13. Birthplace Md.

MOTHER
14. Maiden Name Carolyn Krauss
15. Birthplace Md.

16 (a) Informant Mr. Wm. V. Crider
(b) Address 2 S. Prospect Ave., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Signature of Registrar) SEP 7 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1946, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1946 to Sept. 6 1946 and that I last saw h[illegible] alive on Sept. 6 1946.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hamilton Smith Jr. M.D.
Address St. Agnes Hosp. Date signed 9/6/46

VS 150

G13507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G13507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS MONROE ARMFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Minnie V. Armfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1868

8. AGE: Years	Months	Days	If less than one day
78	1	2	hr. min.

9. Birthplace Mt. Airy, N. C. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Reynolds Tobacco Co.

FATHER
12. Name Martin Armfield
13. Birthplace Mt. Airy, N. C.

MOTHER
14. Maiden Name Pauline Mitchell
15. Birthplace Mt. Airy, N. C.

16 (a) Informant Mrs. Clara R. Heath
(b) Address 912 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 7 - 1946 (Date filed, Registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1946 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1946 to Sept 5 1946 and that I last saw h[illegible] alive on Sept. 5 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	12 days
Due to Generalized Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

75. Signature Philip F. Lerner
Address 2701 W. North Ave. Date signed 9/6/46

X

G43508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G43508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3015 Belmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE CLARK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Daniel Webster Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1871

8. AGE: Years	Months	Days	If less than one day
75	2	17	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John K. Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name -- Lederer
15. Birthplace Maryland

16 (a) Informant Mr. Melvin A. Gale
(b) Address 2941 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed Sept 7 1946 (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1946 to Sept 6 1946 and that I last saw h[illegible] alive on Sept 5 1946

Immediate cause of death
Cerebral Apoplexy — Duration 2 days
Due to Arteriosclerosis — 2 yrs
Due to Chr. nephritis — 2 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. Jos. C. Gaynor
Address 1136 Poplar Grove St. Date signed 9/7/46
Balto 16 Md

G13509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G13509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 W. West St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 W West (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Tobias

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1891

8. AGE: Years	Months	Days	If less than one day
55	8	3	hr. min.

9. Birthplace Newberry S. C. (Town, county, and state)
10. Usual Occupation Farming
11. Industry or business

FATHER	12. Name Robert Tobias
	13. Birthplace S. C.
MOTHER	14. Maiden Name Tepanna Ballman
	15. Birthplace —

16 (a) Informant Mary Tobias
(b) Address 503 W West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) Date received by Local Registrar SEP 7 1946 (b) Thomas Taylor Williamson, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946 at 9 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1946 to Sept 4 1946 and that I last saw him alive on Aug 30 1946.

Immediate cause of death Chronic Hypertension - Cardiac Disease — Duration Twelve

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W Gaines M.D.
Address 562 W Hamburg St Date signed 9/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43510

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. Arbutus & Annapolis Rds.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Brien, Richard Herman Breen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower.

6 (b) Name of husband or wife: Cath Ella Downing

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Feb. 18 [illegible]

8. AGE: Years 54 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Patrick Breen
13. Birthplace: Md.

MOTHER
14. Maiden Name: Sarah E. Spoerer
15. Birthplace: Md.

16 (a) Informant: Mrs. Ellenora Goodwin
(b) Address: 1539 Beech St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 9/46 (month) (day) (year)

(c) Cemetery or crematory: Loudon Pk.
Location: 3801 Frederick Rd.

18 (a) Funeral director: Harry F. Nitsche
(b) Address: 1101 Edmondson Ave.

19 (a) SEP 8 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1946, at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1946, to 9/6 1946, and that I last saw h[illegible] alive on 9/6 1946. Immediate cause of death: Coronary Occlusion

Due to: HEMO -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald W. Munter, M.D.
Address St Agnes Date signed 9/6/46
Howard J. Mercier M.D.
McKinzie X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G43511

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William D. Weigman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215 01 2775

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1877

8. AGE: Years	Months	Days	If less than one day
69	1	9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Presser
11. Industry or business Marlboro Shirt Co.

FATHER
12. Name Wm. D. Weigman
13. Birthplace Md.

MOTHER
14. Maiden Name Anna M. Haefner
15. Birthplace Md.

16 (a) Informant John E. Nee
(b) Address 4505 Hampnett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9/46. (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 101 Edmondson Ave.

19 (a) SEP 9 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946 at 4 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1946 to Sept 6 1946 and that I last saw h— alive on Sept 1 1946

Immediate cause of death — Duration

Carcinoma of Prostate

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1729 W Lombard St Date signed Sept 6 46

VS 150

643512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. 643512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 344 S. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul F. Hohenberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1932

8. AGE: Years 13 | Months 9 | Days - | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Paul F. Hohenberger
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ethel L. Callison
15. Birthplace Balto. Md

16 (a) Informant Paul F. Hohenberger
(b) Address 343 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry F. Kurtz
(b) Address 4101 Edmondson Ave.

19 (a) SEP 8 - 1946 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull, Fractured leg bones

Due to

Other Conditions Lacerations and brush burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-4-46 at 5:30 P.M. 19/4
(b) Where did injury occur? Wilkens Ave at Mount St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Auto & Bicycle Collision

23. Signature Howard J. Mercer Medical Examiner. M.D.
Date signed 9-5-46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

G43513 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Carl Wilson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Separated

6 (b) Name of husband or wife Mary B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/11/89

8. AGE: Years	Months	Days	If less than one day
57	7	26.	hr. min.

9. Birthplace Randers, Denmark
(Town, county, and state)
10. Usual Occupation Chef
11. Industry or business Restaurant

FATHER
12. Name Charles Wilson
13. Birthplace Denmark

MOTHER
14. Maiden Name Unknown
15. Birthplace Denmark

16 (a) Informant Mrs Sam Campbell
(b) Address 4204-15th St N Miami, Fla

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 3930 Hyland Ave

18 (a) Funeral director John F Conway Jr
(b) Address 1803 Pollitt St

SEP 7 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1946, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on Sept 6 1946.

Immediate cause of death	Duration
Circulatory Failure	
Due to Lobar Pneumonia, RL upper, middle & lower lobe,	2 weeks
Due to Left lower lobe.	
Other Conditions Chronic alcoholism	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry E. Nill, M.D.
Address University Hosp Date signed 9/6/46 M. D.

G13518784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1926

G43514
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County
(c) City or town New Providence (If outside city or town limits, write RURAL and give town)
(d) Street No. First Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Coviello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-31

8. AGE: Years	Months	Days	If less than one day
15	6	1	hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rocco Coviello
13. Birthplace Italy

MOTHER
14. Maiden Name Bernadette Addotta
15. Birthplace Italy

16 (a) Informant Nicola
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 7-46 (month) (day) (year)
(c) Cemetery or crematory St THERESA Cem. Location SUMMIT. N. J.

18 (a) Funeral director John D Mitchell & Son
(b) Address 1400 Eutaw Place

19 (a) SEP 7 - 1946 Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1946, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1946 to 9-7 1946, and that I last saw h alive on 9-7 1946.

Immediate cause of death	Duration
Cong. heart anemia & cyanosis	Life.
Due to Operation for ↑	
Due to Cerebral Thrombosis	24 hrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-6-46

Major findings of operation: Pulmonary Stenosis

of autopsy: Cerebral anemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. B. Morrow
Address A. H. N. Date signed 9-7

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43515 BALTIMORE CITY HEALTH DEPARTMENT G43515

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) First Come

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry G. Luttmer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1860

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	3	14		

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Herman Luttmer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Oberman
15. Birthplace Germany

16 (a) Informant Herman O. Luttmer
(b) Address Randallstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 46 (Month) (Day) (Year)
(c) Cemetery or crematory St. Charles
Location Catonsville, Md.

18 (a) Funeral director Frank H. Yeager
(b) Address Catonsville Maryland

SEP 8 1946 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7, 1946, at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1946, to Sept 7 1946, and that I last saw h[illegible] alive on Sept 7 1946.

Immediate cause of death: Cardiac resp failure, — Duration

Due to Arterio Sclerotic Cardio-Vascular Disease & decompensation (Grade IV) — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Connor M. D.
Address Mercy Hosp. Date signed 9-7-46

VS-150

X

G43516

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G43516

CERTIFICATE OF DEATH 46E

Reg. Dist. No. _____

1. PLACE OF DEATH:

County _____

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about a week

Hospital, institution, or street address where death occurred: 1011 Brantley Ave 16

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County _____

City or town Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 1011 Brantley Ave (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME Blanche B. Caswell

3. (b) Social Security Number _____

4. Sex: Female | 5. Color or race: Negro | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Thomas S. Caswell

6.(c) If alive, give age about 55 years

7. Birth date of deceased (mo., day, yr.): May 6, 1888

8. AGE: Years 58 | Months 4 | Days 1 | If less than one day: _____ hrs. _____ min.

9. Birthplace: Philadelphia, Pa (City, county, and state)

10. Usual occupation: School Teacher

11. Industry or business: _____

FATHER

12. Name: Thomas B. Jessup

13. Birthplace: Virginia

MOTHER

14. Maiden name: Josephine Custore

15. Birthplace: Baltimore, Maryland

16. Informant: Miss Josephine Caswell

Address: 7 Monroe St. Aberdeen, Md

17. Burial (Burial, cremation, or removal): Date thereof Sept 12, 1946 (month), (day), (year)

Cemetery or crematory: St. James

Location: Bare de Grace, Md

18. Funeral director: Elmer E. Bullock

Address: Havre de Grace, Md

19. SEP 16 1946 (Date rec'd by registrar) 19 Huntingtown Williams, M... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946, at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1946, to Sept 7 1946

and that I last saw h. on alive on Sept 7 1946

Immediate cause of death: Diphtheria Toxemia

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE J. B. Stewart M.D. M. D. or other

Address 632 W Fayette St. Date signed

G43517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G43517 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Baker Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond S. Ehrlich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1921

8. AGE: Years	Months	Days	If less than one day
25	1	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Contractor-foreman

FATHER
12. Name William Ehrlich
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca Schneider
15. Birthplace Russia

16 (a) Informant Ralph Ehrlich
(b) Address 2006 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8/1946 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Assn
Location Mt Carmel Rd.

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 Pennsylvania Ave Huntington Station, Md.

19 (a) 1946 (To be filled in by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1946, at 3 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock
Fracture of pelvis

Due to Trauma

Other Conditions Intra abdominal hemorrhage
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/9

(a) Date of injury 9-6-46 at 2.30 P. M.
(b) Where did injury occur? 3900 Eastern Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by steel girder

23. Signature George F. Merrill M.D. (Medical Examiner.)
Date signed 9-7-46

VS 191

G43518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43518 Registered No. 1116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1708 Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isidore Stoyenks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Contractor

FATHER
12. Name Harry Stoyenks
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Kramer
15. Birthplace Russia

16 (a) Informant Sarah Stoyenks
(b) Address 1708 N. Appleton st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8/46 (month) (day) (year)
(c) Cemetery or crematory Shaarai Shalom Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W North ave

19 (a) SEP 8 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Sept 1946, at 11:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary Edema
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. J. Helfrich M.D.
Medical Examiner.
Date signed 7 Sept 46

643519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93D

643519 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Hilldale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Farber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Nathan Farber
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Greenbaum
15. Birthplace Austria

16 (a) Informant Louis Farber
(b) Address 2827 Hilldale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept, 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 9 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/46 19 46 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1946, to 9/7 19 46
and that I last saw her alive on 9/7 19 46
Immediate cause of death Peritonitis and ileus
Due to a Mesenteric Thrombosis
Due to
Other Conditions Hypertension and arteriosclerosis C.V. disease
Date of operation 2 years ago
Major findings of operations
of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman Bernstein M.D.
Address Sinai Hosp. Date signed 9/7/46

99

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G43520 — BALTIMORE CITY HEALTH DEPARTMENT — G43520

CERTIFICATE OF DEATH ✓52a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 William St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life—

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 William St. (If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William Stallman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-1711

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ada V. Stallman (nee Reinhardt) 6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) January 16 1887

8. AGE: Years	Months	Days	If less than one day
59	8	21	22 hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Maintainance Man for
11. Industry or business Clerks & Commercial Bldgs.

FATHER — 12. Name Peter Stallman
13. Birthplace Germany

MOTHER — 14. Maiden Name Bertha Mueller
15. Birthplace Germany

16 (a) Informant Mrs. Ada V. Stallman (Wife)
(b) Address 908 William St. Balto. 21 Md

17 (a) Burial — (b) Date thereof (month) Sept. 10 (day) 1946
(Burial, cremation, or removal)
(c) Cemetery or crematory London Park Cem.
Location Balto. Md

18 (a) Funeral director R. Edward Evans
(b) Address 1408 E. Eberdeen St. Balto 31 Md

19 (a) Date received (by registrar) SEP 8 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/ 1946 to 9/6/ 1946 and that I last saw him alive on 9/6/ 1946.

Immediate cause of death Carcinoma involving sacrum and both tuberosities of ischium

Duration: 5 mos.

Due to metastasis probably from Kidney.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

PHYSICIAN
Underline the cause to which death should be charged statistically.

Signature Harry Daiker
Address 1236 Hanover St Date signed 9/7/46 (M. D.)

X

G43521 BALTIMORE CITY HEALTH DEPARTMENT G43521
CERTIFICATE OF DEATH 194a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cemetery age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 Springhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Springhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Kanow
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Esther
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1896
8. AGE: Years 50 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocery Store
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Esther Kanow
(b) Address 2616 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men's
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1457 E Balto St

19 (a) Filed SEP 8 1946 (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6-1946 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1946 to Sep. 6 1946 and that I last saw him alive on Sep. 1 1946

Immediate cause of death: Coronary Heart Disease — Duration 5 m.
Due to
Due to
Other Conditions Embolism — 1 d.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 2040 Eutaw Date signed Sep. 7-46

VS 180

G43522 BALTIMORE CITY HEALTH DEPARTMENT G43522

CERTIFICATE OF DEATH ✓13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 No Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 1228 No Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Goldie Goldfein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 67 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Aaron
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ida
15. Birthplace: Russia

16 (a) Informant: Harry Goldfein
(b) Address: 1228 No Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-46 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Mt Carmel

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1469 E Balto St

19 (a) 8 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27-1946, to 9-7-1946, and that I last saw h alive on 9-7-1946.

Immediate cause of death	Duration
PULMONARY HEMORRHAGE	1 HOUR
Due to TUBERCULOSIS (PULMONARY)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. B. Mary M.D.

Address 448 N. Luzerne Ave Date signed 9-7-46 M. D.

G43523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46c

G43523 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Eutaw Place
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) √yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 2309 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Johanna Vogel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Ludwig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name William

13. Birthplace Germany

MOTHER 14. Maiden Name Adelheid

15. Birthplace Germany

16 (a) Informant Alfred Rosenberg

(b) Address 2309 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1496 Balto St

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7- 1946, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12/ 1946 to 9/6/ 1946 and that I last saw h[illegible] alive on 9/6/ 1946

Immediate cause of death: Cancer of papilla Vateri

Due to: Widely spread Metastases

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: about 4 mths

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. Weinberger M. D.

Address 912 Brooks Lane Date signed 9/11/46

G43524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G43524 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name town)
(d) Street No. 3607 Lucille Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB HYATT

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Minnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (town, county, and state)
10. Usual Occupation Shoe Operator
11. Industry or business

FATHER
12. Name David Hyatt
13. Birthplace Russia

MOTHER
14. Maiden Name Dora
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad & Hamilton Ave

18 (a) Funeral director Jack Levin Sons
(b) Address 2100 Eutaw Pl

19 (a) 1946 (Date rec'd by Registrar) (b) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/46 19 . at 2:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/46 19 . to 9/2/ 1946, and that I last saw him alive on 9/2/46 . 19 .

Immediate cause of death Myocardial infarction

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Potter M.D.
Address Sinai Hosp Date signed 9/2/46 M. D.

VS 150

94a

G43525 G43525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 431 South Paca Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PARKER S. SPRUILL

3 (b) If veteran, name war #2 | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: d.

6 (b) Name of husband or wife Rose G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9-1908

8. AGE: Years 37 yrs. | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Edenton N.C. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Wilk W Spruill
13. Birthplace Chowan Co N.C

MOTHER 14. Maiden Name Nellie V Tynch
15. Birthplace Chowan Co NC.

16 (a) Informant John Lee Spruill
(b) Address Edenton N.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/8/46 (month) (day) (year)
(c) Cemetery or crematory Beaver Hill Cem
Location Edenton N.C.

18 (a) Funeral director Wm Cook Inc.
(b) Address 217 St Paul St.

19 (a) 1946 (Filed by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1946, at 5:20 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH External Hemorrhage due to severed femoral vessels

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/7/46 at 4 A. M.
(b) Where did injury occur? 431 S. Paca Street.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury stab wound (kitchen knife)

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 9-7-46

X

G43526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G43526 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3413 Pinkney Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Pinkney Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MALVINA HAMBURGER.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Henry A. Hamburger 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1865.

8. AGE: Years	Months	Days	If less than one day
80	9	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Moses Pollock,
13. Birthplace Germany.

MOTHER 14. Maiden Name Amelia Schloss,
15. Birthplace Germany.

16 (a) Informant Mrs. Leonard Stromberg,
(b) Address 3413 Pinkney Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/46. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnenschein & Son
(b) Address 1902 Eutaw Place.

19 (a) Filed 1946 (b) Recorded by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7th. 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Aug 1946 to 7 Sept. 1946 and that I last saw her alive on 6 Sept. 1946.

Immediate cause of death: Uremia — Duration 1 week
Due to Arteriolarsclerotic nephritis
Due to Generalized arteriosclerosis
Other Conditions Arterial hypertension

(Include pregnancy within 3 months of death)
Date of operation Not
Major findings of operation: none
of autopsy: no

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon F. Hamburger Jr. M. D.
Address 120[illegible] Eutaw Place. Date signed

Dr. Pokorny G43527
2200 E. Madison

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V94a

G43527 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5426 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Bishop

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: John H. Bishop
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1875

8. AGE: Years 71 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Co. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Milchling
13. Birthplace Germany

MOTHER
14. Maiden Name Eva
15. Birthplace U.S.A.

16 (a) Informant Mr. Elmer J. Hammel
(b) Address 5430 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.9.46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road.

19. (a) Date received by registrar SEP 9 - 1946 (b) Registrar Washington Williams M.D.

VS 500

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6th, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946 to Sept 6 1946 and that I last saw [illegible] alive on Sept 6 1946

Immediate cause of death: Coronary Thrombosis — Duration: 6 weeks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2200 E Madison St Date signed 9/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43528 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 HOMEWOOD AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 HOMEWOOD AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUPHEMIA B. DE PRIEST

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 74 Months - Days - If less than one day hr. min.

9. Birthplace SCOTLAND (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER 12. Name JAMES MORAN

13. Birthplace SCOTLAND

MOTHER 14. Maiden Name ELIZABETH ROBERTSON

15. Birthplace SCOTLAND

16 (a) Informant JOHN DE PRIEST

(b) Address 1118 HOMEWOOD AVE

17 (a) BURIAL (b) Date thereof 9-11-46 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location MT. PLEASANT, PA.

18 (a) Funeral director WIEDEFELD & SON

(b) Address GREEN MOUNT AVE & 22ND ST.

SEP 9 1946 (b)
VS 150 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 8TH 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1946 to 9/7 1946 and that I last saw him alive on 9/7 1946.

Immediate cause of death: Myocarditis

Due to Ch arteriosclerosis

Due to Ch Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hometeau

Address 733 Argyle St Date signed 9/8/46 M. D.

X

G43529 BALTIMORE CITY HEALTH DEPARTMENT G43529

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2578 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2578 W. Baltimore St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Martin Brady Sr.

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret K. Brady
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1895

8. AGE: Years	Months	Days	If less than one day
51	2	18	17 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Retired

FATHER
12. Name Phillip L. Brady
13. Birthplace Maryland

MOTHER
14. Maiden Name Rose Reinhold
15. Birthplace Maryland

16 (a) Informant Margaret K. Brady
(b) Address 2578 W. Baltimore St.

17 (a) Burial (b) Date thereof Sept. 9, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George L. Fahrwald
(b) Address 2101 Frederick Avenue

SEP 9 1946 Huntington Williams M.D.
(Date received by registrar) Registrar

AS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1946 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1946, to Sept 6 1946, and that I last saw h[illegible] alive on Sept 5 1946

Immediate cause of death Intracranial hemorrhage

Duration

Due to Hypertension - arterial

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Abbie H. Crowther
Address 409 Fund. Ave Date signed 9/7/46 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G43530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G43530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ 23, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 Gorman Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Stella Z. Lersch (Lersch)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife: John L. Lersch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 15 Jan 1900

8. AGE: Years	Months	Days	If less than one day
46	2	22	21 hr. min.

9. Birthplace Jeanesville Penn.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name William Carney
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rebecca Mathias
15. Birthplace Pennsylvania

16 (a) Informant John Leroy Lersch
(b) Address 36 Gorman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Swaggerty & Hurst
(b) Address 201 Frederick Avenue

19 (a) (Date rec'd by registrar) (b)

SEP 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Sept. 1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Aug. 1946 to 6 Sept. 1946 and that I last saw h.e.r. alive on 4 Sept. 1946.

Immediate cause of death: Coronary embolism & thrombosis — Duration

Due to

Due to

Other Conditions Marked obesity.
(Include pregnancy within 3 months of death)

Date of operation 8/21/46

Major findings of operation: Fistula in ano

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M.T. McGrogan

Address Maryland Gen. Hosp. Date signed 6 Sept 46 M. D.

M.T. McGrogan

G73531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 4512 G73531

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 E 31st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 E 31st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John D Lutzrath

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 213-10-5444

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Blanche E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1. 1877

8. AGE: Years	Months	Days	If less than one day
69	5	5	hr. min.

9. Birthplace Berlin Germany (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name John C Lutzrath
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Miluvious
15. Birthplace Germany

16 (a) Informant Katherine A Russet
(b) Address 1625 E 31st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-9-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Gilbert & Son
(b) Address 1219 E Fort Ave

Sept 9 1946 Huntington Williams M.D. (Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Sept 6 1946 and that I last saw h[illegible] alive on Sept 6 1946

Immediate cause of death

Carcinomatosis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fritz J. Hinzen
Address 2700 Harford Rd Date signed Sept 6 1946

VS 150

G43532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

Registered No. G43532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Hope St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter R Reifner

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Candonia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years 86 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs. Ida Widey Dgr
(b) Address: 2719 Berwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/9/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Mt Carmel
Location: Balto. Md.

18 (a) Funeral director: William Cook Dgr.
(b) Address: 1217 St. Paul St.

19. Date and time of registration: SEP 9 - 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/6 1946 at 6 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1946 to 9/6 1946 and that I last saw h[illegible] alive on 9/6 1946

Immediate cause of death: (a) Cardiac Failure — Duration
Due to: (b) Arteriosclerosis Cardiac Failure.
Other Conditions: Anemia Cystitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Hypostatic Pneumonia Both Lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Peter R Reifner M.D.
Address: St Joseph's Hospital Date signed: 9/6/46

G43533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G43533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Eutaw Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Venia Green Gilley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	D.

6 (b) Name of husband or wife Glen.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER 12. Name Brascue Green
13. Birthplace Kentucky

MOTHER 14. Maiden Name Zilfie Mootre
15. Birthplace Kentucky

16 (a) Informant Brascue Green
(b) Address Kentucky

17 (a) Removal (b) Date thereof 9/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Flatwoods
Location Kentucky

18 (a) Funeral director Wm. J. Cook Inc
(b) Address 1217 St Paul St.

SEP 9 - 1946 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Sept. 7, 1946, at 2.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of abdomen producing
shock + hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/7/46 at 1.45 A. M.
(b) Where did injury occur? 521 E. Baltimore St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public, While at work? No
(d) Means of injury Gun shot wound

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-7-46

X

G43534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G43534 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gaynor and Dukeland, Balto 16.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Herbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luetta Catherine McDermott

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John G. McDermott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1916

8. AGE: Years	Months	Days	If less than one day
30	5	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Milton S. Fee
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertie Decker
15. Birthplace Balto., Md.

16 (a) Informant Mr. John G. McDermott
(b) Address 2102 Herbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 9 1946 (Signature of registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 September 1946, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Aug 1946, to 6 Sept 1946, and that I last saw her alive on 6 Sept 1946.

Immediate cause of death	Duration
Respiratory Failure	2 hrs.
Due to Pulmonary Edema	12 hrs.
Due to Paralytic Ileus following operation for closure of recto-abdominal fistula	5 days
Other Conditions Carcinoma, colorectal	

(Include pregnancy within 3 months of death)

Date of operation 26 Aug '46
Major findings of operations: Recto-abdominal, recto-vesical and recto-vaginal fistulae
Autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Bell, M. D.
Address West Baltimore General Hospital Balto 16, Md. Date signed 6 Sept 46

G43535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA V. GIPE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Albert B. Gipe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1864

8. AGE: Years	Months	Days	If less than one day
82	7	-	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Thomas Humphreys
13. Birthplace:

MOTHER
14. Maiden Name: Charlotte Jones
15. Birthplace: Md.

16 (a) Informant: Miss E. Virginia Gipe
(b) Address: 417 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

SEP 9 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 19 46 at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Sept 6 1946 and that I last saw h[illegible] alive on Sept 6 1946.

Immediate cause of death
Lung Cancer
Pneumonia
Due to Arterial Sclerosis
Due to
Other Conditions Age
(Include pregnancy within 3 months of death)

Duration
3 days
10 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 9958 Harford Date signed 9-7-46 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43536 — BALTIMORE CITY HEALTH DEPARTMENT — G43536

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Calvert
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Tregy Goldsborough

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Neg	No	Fem	white	

6 (b) Name of husband or wife: O
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1893

8. AGE: Years	Months	Days	If less than one day
63	2	10	hr. min.

9. Birthplace Howard Co. Md
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business Home -

FATHER
12. Name Charles Goldsborough
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Galt
15. Birthplace Virginia

16 (a) Informant Sister Miss Ellen Goldsborough
(b) Address 10 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1937 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) [illegible] Washington Williams, M.D.

SEP 9 - 1937

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1937, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1937, to Sept 6 1937, and that I last saw alive on Sept 6 1937.

Immediate cause of death	Duration
Respiratory failure	21 days
Due to Hemorrhagic cerebral embolism thrombosis	
Due to Carcinoma Sclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur F. Maer M. D.
Address Union Memorial Hospital Date signed 9/6/37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G43537 BC# G19513 BALTIMORE CITY HEALTH DEPARTMENT ✓1096 G43537

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 years
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town.)
(d) Street No. 921 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

PERSONAL AND STATISTICAL PARTICULARS

3. (a) FULL NAME Douglas Eugene Leighton ✓
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 9, 1945
8. AGE: Years 1 Months 18 Days 27 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business
12. FATHER Name James Leighton
13. Birthplace South Carolina
14. MOTHER Maiden Name Lillian Leighton
15. Birthplace North Carolina
16 (a) Informant Rev. Leighton
(b) Address 921 Madison Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery [redacted] Mt. Calvary
Location Cedar Hill, Md.
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.
19 (a) (Date received by registrar) (b) SEP 9 - 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1946, at 6 15 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 12 30 AM 9/6 1946 to 6 15 AM 9/6 1946, and that I last saw him alive on Sept. 6 1946.

Immediate cause of death	Duration
Overwhelming Toxemia	3 days
Due to Carcinomatosis	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John C. Morrison M. D.
Address Univ. Hosp. Date signed 9/6/46

X

G43538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

√46E G43538

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2401 Ashland Ave, √ Ward)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 6 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Harry Margolies

If U. S. Veteran specify WAR

(a) Residence: No. 2401 Ashland Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Dora

6. DATE OF BIRTH (month, day, year) 1887

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Tailor

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Isadore

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Fannie

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Nathan Margolies

(Address) 240, Ashland Ave

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Rosedale Date 9-9- 19 46

19. UNDERTAKER Jack Lewis Inc

(Address) 1709 E Balto St

20. FILED SEP 9 - 1946 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9-6- 19 46

22. I HEREBY CERTIFY, That I attended deceased from 7 SEPT 19 46 to 8 SEPT. 19 46

I last saw him alive on SEPT. 1 19 46 Death is said to have occurred on the date stated above, at 1.30 A.m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
CARCINOMA OF INTESTINE	6 MOS
METASTASIS GENERALIZED	4 MOS

Other contributory causes of importance:

Was an operation performed? YES Date of 4 MOS AGO

For what disease or injury? INTESTINAL OBSTRUCTION

Name of operation LAPAROTOMY

What test confirmed diagnosis? Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Benjamin H. Grafton M. D.

(Address) 121 S. Hilton Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G43539 G43539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1362

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1337-N. Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1337. N. Stricker St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary B. Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Henry Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896
8. AGE: Years 50 yrs. Months Days If less than one day hr. min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Bishop

FATHER
12. Name George
13. Birthplace N. C.

MOTHER
14. Maiden Name Emanda Anderson
15. Birthplace N. C.

16 (a) Informant Sadie Johnson
(b) Address 1337. N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Arlington Cem. Mt. Auburn Cem.
Location West Port. Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 903 N. Mount St. Balto. Md.

19 SEP 9 - 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7, 1946 at 12:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Aug 1946. to 7 Sept 1946. and that I last saw her alive on Aug 31 1946.

Immediate cause of death Bronchial Pneumonia — Duration 3 wks
Due to Chr. Fibroid Phthisis — ?
Due to
Other Conditions Cachexia

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theo. Pfefer X
Address 1422 E. Pratt Date signed 9/7/46

G43540 D 46145

BALTIMORE CITY HEALTH DEPARTMENT X G43540

CERTIFICATE OF DEATH 122 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga - (b) County
(c) City or town Atlanta
(If outside city or town limits, write RURAL and give town)
(d) Street No. 350 Clifton Rd -
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Shaw -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-42

8. AGE: Years 4 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Claude Shaw
13. Birthplace Georgia

MOTHER
14. Maiden Name Elizabeth Hembree
15. Birthplace Georgia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9/46 (month) (day) (year)

(c) Cemetery or crematory West View
Location Atlanta, Ga

18 (a) Funeral director John P. Mitchell Sons
(b) Address 1900 Eutaw Place

SEP 9 1946 (Date rec'd by local registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1946 at 6 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24th 1946 to Sept 8 1946 and that I last saw h[illegible] alive on Sept 8 1946

Immediate cause of death — Duration

Pulmonary edema
Cardiac failure
Due to: Lues [illegible] (syphilis)

Due to

Other Conditions Pregnancy
Generalized allergic state
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George L Palmer
Address Johns Hopkins Hosp Date signed 9-8-46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V124B

Registered No. G43541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Duncan E. Bryant

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 713-17-3871

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married Husband

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/94

8. AGE: Years 51 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Mass (Town, county, and state)

10. Usual Occupation Circul. manager - newspaper

11. Industry or business newspaper

FATHER
12. Name Duncan E. Bryant
13. Birthplace N. York

MOTHER
14. Maiden Name Mary M. Levi
15. Birthplace N. York

16 (a) Informant Mary M. Bryant
(b) Address 1573 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Pott C. B. M. Walter
(b) Address Pott & Stricker Ch.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS Form SEP 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946, at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30/46 19 to 9/6/46 19, and that I last saw h. alive on 9/6/46 19.

Immediate cause of death: pneumonia — Duration

Due to uremic coma

Due to liver cirrhosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. North J.
Address Bon Secours Hosp. Date signed 9/6/46

X

D.O.A - accident Room BALTIMORE CITY HEALTH DEPARTMENT To be removed by medical examiner

G13542 CERTIFICATE OF DEATH V131 B Registered No. 12542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARON RECEIVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Wallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Killy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 26 1900

8. AGE: Years	Months	Days	If less than one day
46	4	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Addison C. Aquilla
13. Birthplace Md

MOTHER 14. Maiden Name Maria Proctor
15. Birthplace Balto

16 (a) Informant Marie Davis
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

SEP 9 1946 (Date filed) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946 at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Sept 4 1946 and that I last saw [illegible] alive on Sept 4 1946

Immediate cause of death Uremia — Duration 1 yr

Due to Chronic Glomerulonephritis — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Lowden by Carey
Address Johns Hopkins Hosp Signed Sept 5 1946

For H. W. D. Hopkins, by Howard J. Mackie, M.D. X

G43543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G43543 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Oakford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Oakford Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Frank J. McComas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20-1866

8. AGE: Years	Months	Days	If less than one day
79	10	17	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self.

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant William F. McComas
(b) Address Rd 1 Monkton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park -
Location

18 (a) Funeral director Charles P. Powell
(b) Address 2427 Edmondson Ave

19 (a) (Registrar's signature) Registrar
(b) SEP 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/ 1946, at 8:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/1 1946, to 9/7/ 1946 and that I last saw h[illegible] alive on 9/7 1946

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	few yrs
Due to Hypertension	3 weeks
Due to Coronary Thrombosis	2 weeks
Other Conditions Myocardial Infarct	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex A. Weinstock M. D.
Address 4603 York Rd Date signed 9/8/46

Birth Certificate G43544 B-55922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G43544 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Lytle St
(c) Hospital or institution: South Balto. Genl Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Decatur St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl (A) Furman (Twin)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/4/46

8. AGE: Years | Months | Days 2 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Farley Furman
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Evelyn May Tormollan
15. Birthplace Baltimore

16 (a) Informant Evelyn Furman
(b) Address 1414 Decatur St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Savior Cem. Co.
Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dill.
(b) Address 1501 E Fort Ave

19 (a) (Date received by registrar) (b) Huntington Williams, Mgr. (Signature of registrar)

VS SEP 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1946 at mid night M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Sept 1946 to 7 Sept 1946 and that I last saw h.e.r. alive on 7 Sept 1946

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions Possible Hemorrhage in placenta (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cohen M. D.
Address South Bend 6-14 Date signed 7 Sept 46

X

G43545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43545 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Mystle Ave,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Mystle Ave, (If rural, give location.)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham Williams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Georgia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 4, 1863

8. AGE: Years	Months	Days	If less than one day
82	9	1	hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation Janitor.
11. Industry or business

FATHER
12. Name William Williams.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Mitchell.
15. Birthplace Md.

16 (a) Informant Gladys E. Banks.
(b) Address 1009 Mystle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9 1946 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Balto., Md.

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

SEP 9 - 1946 (a) Date received by registrar (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1946 5.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to Sept 5 1946 and that I last saw h[illegible] alive on Aug 1 1946

Immediate cause of death — Duration

Acute Cardiac Failure

Due to Myocarditis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Howell & Son, M.D.

Address 601 N. Carrollton Ave Date signed 9/9/46

G43546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43546 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 753 McHenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Lucy C. Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Grason Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1868

8. AGE: Years	Months	Days	If less than one day
58	4	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name William White
13. Birthplace Md.

MOTHER
14. Maiden Name Anna F. Durnell
15. Birthplace Md.

16 (a) Informant Mrs. Robert Burns
(b) Address 27 Meadow Ct Govans Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-46 (month) (day) (year)
(c) Cemetery or crematory Balto Co.
Location Balto Md.

18 (a) Funeral director Edward Strong
(b) Address 3207 W North Ave

19 (a) Filed Sept 9 1946 (b) Signature Hattie Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946 at 2:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1946 to Sept 8 1946, and that I last saw her alive on Sept. 8, 1946.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Pulmonary edema and Cerebro-vascular accident	
Due to Hypertensive Cardiovascular disease Cardiac failure.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Date signed 9/8/46

Hosp. X

G43547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G43547

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes & Dukeland
(c) Hospital or institution Mt Dacts Gen Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 N. Day St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Abate

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Poland

MOTHER
14. Maiden Name Antonina FIALKOWSKA
15. Birthplace Poland

16 (a) Informant Walter Bialek
(b) Address 325 Lorraine Ave.

17 (a) Burial (b) Date thereof 9/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore

18 (a) Funeral director F. W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) SEP 9 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Sept 1946 at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Sept 1946 to 7 Sept 1946 and that I last saw h 1½ alive on 7 Sept 1946

Immediate cause of death Cardiac Insufficiency — Duration

Due to Pulmonary Edema

Due to Coronary Thrombosis + Congestive Failure

Other Conditions Hypertension Arteriosclerosis C.V. Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis A. Hale M.D.
Address Mt Dacts Gen Hosp Date signed 9/5/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G43548 ZERN BALTIMORE CITY HEALTH DEPARTMENT G43548

CERTIFICATE OF DEATH

137a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Youngstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Clinton St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Zern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Zern
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) September 5 1870

8. AGE: Years	Months	Days	If less than one day
71	11	26 24	hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Mechanic
11. Industry or business

MOTHER / FATHER
12. Name Frederick Zern
13. Birthplace Germany
14. Maiden Name Ernestine Wentt
15. Birthplace Germany

16 (a) Informant Margaret Zern
(b) Address 210 Clinton St Youngstown O

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-46 (month) (day) (year)
(c) Cemetery or crematory Youngstown Ohio
Location

18 (a) Funeral director Lloyd E. Nilch
(b) Address 1606 N Charles St

19 (a) SEP 9 1946 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Sept 9 1946, and that I last saw h alive on Sept 9 1946

Immediate cause of death Cardio-respiratory failure — Duration

Due to

Due to

Other Conditions Sepsis - pubis Contusion
Sepsis - pubis Prostatitis
(Include pregnancy within 3 months of death)

Date of operation Sept 2, 1946 - Sept 7, 1946

Major findings of operation Prostatic hypertrophy

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence E. McWilliams Jr. M. D.
Address Mercy Hospital Date signed 9-9-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G13549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G13549
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HB #102807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 24
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 953 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Jones Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife Rebecca (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1902

8. AGE: Years	Months	Days	If less than one day
44	6 5	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Jones (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Florence ? (d)
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore County Md

18 (a) Funeral director Wm. Arthur Elliott & Son
(b) Address 1129 N. Caroline St. Baltimore

SEP 9 1946 (Date rec'd by local registrar) Huntington Williams Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1946, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1946 to Sept. 5 1946 and that I last saw h in alive on Sept. 5 1946

Immediate cause of death: Pulmonary Tbc. Far Adv. — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Haut M. D.
Address Balto City Hosp Date signed 9/6/46

X

GA3550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73B

Registered No. GA3550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland St Josephs Hospital
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 O'Donnell St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mrs. Josephine F. Marzec

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Stanley

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 26 | Months | Days | If less than one day: hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name George Darlak

13. Birthplace Balto Md

MOTHER 14. Maiden Name Veronica Doppler

15. Birthplace Balto Md

16 (a) Informant Mr. Stanley Marzec.

(b) Address 3106 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10/46 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem

Location Dundalk Ave

18 (a) Funeral director Mayo E. Fiathowski

(b) Address 1800 S. Kenwood ave.

SEP 9 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946 at 1:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946, to Sept 7 1946, and that I last saw h[illegible] alive on Sept 7 1946.

Immediate cause of death | Duration

Idiopathic aplastic anemia.

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Richard A. Young M. D.

Address St. Josephs Hosp. Date signed 9/9/46

G43551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

Registered No. G43551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in years, months, days, hours, minutes for every case under one year of age. Be specific and write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital 9th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 E. 29th. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Thomas R Witter (THOMAS RICHARD WITTER)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Katherine S. Petz
6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1864

8. AGE: Years	Months	Days	If less than one day
81	11	8 2 2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Appeal Tax Court - Ret.

11. Industry or business Baltimore City

FATHER
12. Name Adam Frederick Witter
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Pfaff
15. Birthplace Germany

16 (a) Informant Mr. Alfred Witter
(b) Address 1717 E. 29th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/46 (month) (day) (year)
(a) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

SEP 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Sept 6 1946 and that I last saw h[illegible] alive on Sept 6 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arterio-sclerosis	
Due to Intestinal Obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard A. Young
Address St. Joseph's Hosp Date signed 9/7/46

G43552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G43552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave
(c) Hospital or institution:
Pineridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wk.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Shamrock Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE A. KIMMELSHUE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Geo. E. Kimmelshue
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 21, 1880

AGE: Years	Months	Days	If less than one day
66	4	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fred Gardner
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Schlitzberger
15. Birthplace Germany

16 (a) Informant George E. Kimmelshue
(b) Address 4215 Shamrock Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

SEP 9 - 1946 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH September 5 1946, at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/1945 to Sept 5 1946.
and that I last saw h ve alive on Sept 5 1946.

Immediate cause of death. Duration

Cerebral Hemorrhage	3 mos
Due to Essential Hypertension	?
Due to	
Other Conditions Bastric Carcinoma	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Krolle M. D.
Address 1801 Eutaw Place Date signed 9/6/46

G43553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

117a

Registered No. G43553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 426 N. Curley St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Curley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] AMEAL J. Drummer

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Lucelia Drummer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1901

8. AGE: Years	Months	Days	If less than one day
44	10	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Garage Mech
11. Industry or business

FATHER 12. Name John Drummer
13. Birthplace Germany

MOTHER 14. Maiden Name K. Sulit
15. Birthplace Germany

16 (a) Informant Roy A. J. Drummer
(b) Address 426 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/46 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Baltimore
Location

18 (a) Funeral director Chilvers Bourgeois Sons
(b) Address 204 Orleans St

SEP 9 - 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1946, at 10.55 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Peritonitis

Due to perforated ulcer of stomach

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/7/46

G43554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c G43554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONTINUED ON BACK OF CERTIFICATE

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 E Federal St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Butler Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 E Federal St (If rural give location)
(e) Citizen of foreign country? No No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. A. Walkemeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ John H Walkemeyer 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14-1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
79	-	- 21		

9. Birthplace Butler Md (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business -

FATHER
12. Name John H. Pickel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Edward H. Walkemeyer
(b) Address 717 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9-46 (month) (day) (year)
(c) Cemetery or crematory Immanuel Lutheran
Location Laurelle Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) (b) (Signature of local registrar)

SEP 9 - 1946 Huntington Mills, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5, 1946 at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3- 1937 to 9-5- 1946 and that I last saw her alive on 9-5- 1946.

Immediate cause of death	Duration
Acute dilatation of heart	12 hours
Due to Parkinson's Disease	7 yrs
Due to Generalised arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lacy M. D.
Address 2117 Belair Rd Date signed 9-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43555 Registered No.

G43555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Hilltop Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Pomory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 1922

8. AGE: Years 23 Months 11 Days 20 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Md. Drydock

FATHER
12. Name Mac Pomory
13. Birthplace Hungary

MOTHER
14. Maiden Name Elizabeth Baker
15. Birthplace Budapest, Hungary

16 (a) Informant Albert P. Pomory
(b) Address 1413 Decatur Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Glenburnie Md

18 (a) Funeral director Milton Hamilton
(b) Address 3914 Eastern Ave

19 (a) Date received by Registrar SEP 9 1946 (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1946 at 1 12 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Abdominal hemorrhage

Due to Rupture of liver and spleen

Other Conditions Fractured ribs on right, fractured left femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-46 at a.a. Rte. 1 M.
(b) Where did injury occur? Potee Highway - Dark from city limits
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Thrown from motorcycle

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43556 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 1316

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3460 S. Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3460 S. Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emil P. Schultz Jr

3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Amy L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/1868

8. AGE: Years 78 79 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Retired Store Keeper
11. Industry or business —

FATHER
12. Name Emil Schultz Sr
13. Birthplace Germany

MOTHER
14. Maiden Name Martine Barth
15. Birthplace Germany

16 (a) Informant Mrs Caroline Schlabach
(b) Address 3460 S. Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md

18 (a) Funeral director Milton Schilling
(b) Address 2914 E. Monument St

SEP 9 - 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946, at 4.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1946 to Sept 7 1946 and that I last saw him alive on Sept 7 1946

Immediate cause of death Pneumonia — Duration

Due to Congestive Hepatitis

Due to

Other Conditions Anemia Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 208 Belgrade Rd Date signed

VS 190

(over)

G43557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G43557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. 1400 N Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Havenwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry S. Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16/62

8. AGE: Years	Months	Days	If less than one day
83 84	8	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business None

FATHER
12. Name Michael Dunn
13. Birthplace Baltimore

MOTHER
14. Maiden Name Susan Cantler
15. Birthplace Baltimore

16 (a) Informant Miss Marie Dunn
(b) Address 1214 Havenwood Rd

17 (a) Burial (b) Date thereof 9/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. T. Means & Son
(b) Address 805 N. Calvert St.

(c) SEP 9 - 1946 Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/46 19 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7/46 19 to 9/8/46 19, and that I last saw him alive on 9/8/46 19.

Immediate cause of death: Acute Cardiac Failure — Duration

Due to: Cardiac Strain & Myocarditis (Chr.)

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Turner M. D.
Address St. Joseph's Hosp. Date signed 9/7/46

G43558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43558 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 E 21st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 E 21st St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene Lyons

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Lyons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1903

8. AGE: Years 43 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name John T. Dorsey
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Eva Able
15. Birthplace Baltimore - Md

16 (a) Informant William T. Dorsey
(b) Address 1940 W. Franklin ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md

18 (a) Funeral director Durward D. Covington
(b) Address 2/0 W. 25th ST.

19 (a) SEP 9 - 1946 (State registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1946, at 2 45 PM

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h c death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. G. Schmidt M.D. Medical Examiner.
Date signed 9/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43559 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 159

Registered No. G43559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 320 S. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Dumhart

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 Sept 1946

8. AGE: Years	Months	Days	If less than one day
—	—	4	hr. min.

9. Birthplace University Hospital Baltimore (Town, county and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Henry Lindsey Dumhart
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma Mary Waltman
15. Birthplace Baltimore

16 (a) Informant Mrs Henry L. Dumhart
(b) Address 320 S. Franklintown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 Sept 46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md

18 (a) Funeral director H. B. Hilbert & Son
(b) Address 1300 Eutaw Place

19 SEP 9 - 1946 (b)
Filed Washington Hill Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Sept 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Sept 1946, to 8 Sept 1946, and that I last saw h alive on 8 Sept 1946.

Immediate cause of death: Atelectasis — Duration 4 days
Due to: Prematurity — 4 days
Due to:
Other Conditions: Delivered by section for placenta previa
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Miller M. D.
Address University Hosp. Date signed 9-8-46

X

AB-106103 G13560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G13560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution Baltimore City Hospitals 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4122 Delaware Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine Kritz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13- 1862

8. AGE: Years 84 | Months 9- | Days 23 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Methais or Methias Judd
13. Birthplace Germany

MOTHER 14. Maiden Name Wilhemina Bower
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ulloyd Funeral Home
(b) Address 2008 Orleans St.

19 (a) Huntington Williams M.D. (Date rec'd by registrar) Registrar

SEP 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6- 1946, at 8.20PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28- 1946 to 9-6 1946, and that I last saw her alive on 9-6 1946.

Immediate cause of death: Circulatory Failure — Duration 2 wks

Due to Coronary Thrombosis — 3 wks

Due to Coronary Artery Sclerosis

Other Conditions Diaphragmatic Hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Coronary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer S Beasman
Address Baltcity Hosp Date signed 7 Sept 46

X

G43561 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 93 — Registered No. G43561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 S Robinson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimas (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S Robinson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Louis Maasen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Maasen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1873

8. AGE: Years	Months	Days	If less than one day hr.	min.
73	5	20		

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation Lamp lighter
11. Industry or business street

FATHER
12. Name George Maasen
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Schmetzler
15. Birthplace Bavaria

16 (a) Informant Mrs Anna Maasen
(b) Address 414 S. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 7008 Orleans St

19 (a) SEP 9 - 1946 Registrar Huntington Williams, M.D. Registrar
(b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946 at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1946 to Sept 7 1946 and that I last saw h[illegible] alive on Sept 6 1946.

Immediate cause of death: Arteria - selerotic cardio vascular disease with hypertension — Duration: years

Due to

Other Conditions (Senility) — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Nowak

Address 408 S Patt. Pl. Date signed 9/7/46

X

G43562 ✓ G43562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 E. 22nd St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Asa Needham

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War No 1	705-05-0144

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Madge E. Needham
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1880

8. AGE: Years	Months	Days	If less than one day
65	8	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Civil Engineer
11. Industry or business Bridge Builder

FATHER
12. Name Asa Needham
13. Birthplace Baltimore

MOTHER
14. Maiden Name Caroline E. Hollingsworth
15. Birthplace Baltimore

16 (a) Informant Mrs. Madge E. Needham
(b) Address 423 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) Date received by local registrar SEP 9 - 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to Sept 4 1946. and that I last saw HIM alive on Sept 3 A.M. 1946.

Immediate cause of death	Duration
Cardiac Respiratory failure	
Due to C A of Prostate	
Due to Possible metastases	
Due to	
Other Conditions Bilateral Orchidectomy	

(Include pregnancy within 3 months of death)
Date of operation Feb. 1, 1946
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams M.D.
Address Mercy Hospital Date signed 9-8-46

X

G43563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G43563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Av. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 5023 Roland ave (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country England

3 (a) FULL NAME Mrs. Anne Ruddock Hambleton

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William Hambleton
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28, 1870

8. AGE: Years: 76 | Months: 5 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Birmingham, England (Town, county, and state)

10. Usual Occupation: -Housewife

11. Industry or business:

FATHER
12. Name: Thomas W. Ruddock
13. Birthplace: Wales

MOTHER
14. Maiden Name: Isabelle V. Potter
15. Birthplace: England

16 (a) Informant: Mrs. E. J. Ahlhauser
(b) Address: Severna Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto. Huntington Hotel Annex, Md.

SEP 9 - 1946 (Date rec'd by registrar) Huntington Hotel Annex, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946 at 3:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29, 1946 to Sept 8 1946, and that I last saw h[illegible] alive on Sept 8, 1946.

Immediate cause of death: Cardio-respiratory failure — Duration:
Due to: Carcinoma of st. breast with metastasis generalized
Due to: especially to skin and lungs
Other Conditions: Hypertensive Arteriosclerotic Heart Disease. Gen. Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Carcinoma of breast with metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Leon Toby M.D.
Address: West Balto. Gen. Date signed 9/8/46

VS 150

G43564

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43564 Registered No.

CERTIFICATE OF DEATH 115B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 W. Lorraine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 W. Lorraine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH BUCHWALD ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. --

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: separated

6 (b) Name of husband or wife: John G. Buchwald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1874

8. AGE: Years 71 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Graf, Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Frederick
15. Birthplace Germany

16 (a) Informant Miss Marie Buchwald
(b) Address 202 W. Lorraine Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Loacker Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1946, at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Sept 7 1946, and that I last saw h[illegible] alive on Sept 6 1946.

Immediate cause of death	Duration
Arteriosclerosis generalized	?
Arthritis - Hypertrophic	?
Due to Staphylococcus Throat	3 days.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest J. Kline M. D.
Address 2627 E. Monument Date signed 9/11/46

VS 180

G43565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

307

Registered No. G43565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Bolton Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Franklin Engel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Laura P. Engel

6 (c) If alive, give age 347 years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1891

8. AGE Years	Months	Days	If less than one day: hr.	min.
(55) 54	7	4		1892

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Night manager- Garage

11. Industry or business Truck Rental Co.

FATHER
12. Name John E. Engel.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anne S. Schaffer
15. Birthplace Baltimore

16 (a) Informant Mrs. ~~Carive~~ Laura P. Engel (wife)
(b) Address 2109- Bolton St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 109 W. Mt. Royal Ave.

19 (a) Date received SEP 9 1946 (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946, at 11.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intrapericardial Hemorrhage

Due to Ruptured aortic aneurysm

Other Conditions Hypertrophy and dilatation of heart.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/9/46

Huntington Station, Md.

X

TYPING WHITE PAPER, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 64

G43566 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Lawrens St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Lawrens Street.
(If rural give location)
(e) Citizen of foreign country? No Colored (Yes or No)
If yes, name country

3 (a) FULL NAME Yvonne Hoskett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1946

8. AGE: Years	Months	Days	If less than one day
	6		hr. min.

9. Birthplace Cal. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Clarence Hoskett
13. Birthplace Va.

MOTHER
14. Maiden Name Ecleen Jennings.
15. Birthplace Va.

16 (a) Informant Clarena Hoskett
(b) Address 1601 Laurens st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/46 (mo.) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port Balto Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 1005 N. Mount St. Inc.

19 (a) Huntington Williams, M.D. (Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946. at 1.10 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Status Thymico Lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/9/46

G43567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 13

G43567 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Eldorado Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Domina Catalano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Antonia Catalano
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 5/1/85

8. AGE: Years	Months	Days	If less than one day
61	4	7	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER
12. Name Charles Catalano
13. Birthplace Italy

MOTHER
14. Maiden Name Nathanson
15. Birthplace Italy

16 (a) Informant Charles J. Catalano
(b) Address 38 S. Dundalk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11/1946 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore Md.

18 (a) Funeral director Harry A. Annarelli
(b) Address 4204 Ridgewood Ave

19 (a) (Date received by Registrar) (b) Registrar

SEP Huntington Pellegrini, M.D.

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1946 to 9-8 1946, and that I last saw him alive on 9-7 1946.

Immediate cause of death Respiratory failure — Duration

Due to Ca of stomach

Due to

Other Conditions Secondary Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Markley, M.D.
Address Bon Secours Hosp. Date signed 9-8-46

X

G43568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G43568 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Wilcox St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Wilcox St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Baker

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John Thomas Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22, 1878

8. AGE: Years 68 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at Home

FATHER
12. Name Patrick Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Ireland

16 (a) Informant Mr. Robert J. Baker
(b) Address 1316 Wilcox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date received by registrar) (b) Kensington Hilligues, M.D. Registrar

SEP 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1946, at 3:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947 to Sept 3 1946, and that I last saw h ER alive on Sept 3 1946.

Immediate cause of death: Chronic myocarditis
Due to: superficial suppuration
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Hal Denton M. D.
Address 1250 E. North Ave. Date signed Sept 9, 1946

AB-93458 G43569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G43569

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-4mos-3days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Homewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Honor Carr

3 (b) If veteran, name war	3 (c) Social Security Account No.
←	←

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	~~Widowed~~ Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1874 or 1873

8. AGE: Years	Months	Days	If less than one day
72-or-73	3	6 7	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bartholew Carr (Dead
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Laffey (Dead
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 10 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd
18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E Eager st.
19 (a) SEP 9 - 1946 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7- 19 46 at 10.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4- 1945 to 9-7 19 46.
and that I last saw h 9T alive on 9-7 19 46.

Immediate cause of death Confluent Bronchopneumonia

Due to Diabetes Mellitus Hypertensive & Arteriosclerotic

Due to C-V Disease

Contributing Pyelonephritis

Other Conditions Chronic Cholecystitis Old Hemiplegia, Lt.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Fauls M. D.
Address Balto City Hosps Date signed 9-7-46

VS 150

(1) G43570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43570
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4907 Queensbury Ave.
(c) Hospital or institution: ****
(d) Length of stay in hospital or inst. (yrs., mos., or days) * * 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4907 Queensbury Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Borgmeier

3 (b) If veteran, name war ****
3 (c) Social Security Account No. ****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna B Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1867

8. AGE: Years	Months	Days	If less than one day
79	2	8 7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired Baltimore Fire Dept
11. Industry or business Lineman

FATHER
12. Name Adam Borgmeier
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Magdaline Hamper
15. Birthplace Germany

16 (a) Informant Mrs Thomas Simpson
(b) Address 4907 Queensbury Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Baltimore Md

18 (a) Funeral director J Melville Jenkins
(b) Address 2715 Kirk Ave

19 (a) (Date received) SEP 9 1946 Huntington Williams M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1946, at 9.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to September 1946, and that I last saw him alive on Sept. 6, 1946.

Immediate cause of death: Cerebral Hemmorhage — Duration: sudden

Due to Hypertensive arteriosclerotic Cardiovascular disease

Due to with 2nd degree decompensation.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Borgmeier
Address 5145 Park Heights Ave Date signed Sept 7 46

X

G43571 BALTIMORE CITY HEALTH DEPARTMENT G43571
CERTIFICATE OF DEATH 46E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town 2302 E. Preston St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Royal

3 (b) If veteran, name war
3 (c) Social Security Account No. 218-05-9199

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1900

8. AGE: Years	Months	Days	If less than one day
40	3	28	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Packer
11. Industry or business Packing House

FATHER
12. Name Julius B. Royall
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Ann Leidig
15. Birthplace Va.

16 (a) Informant Mrs Gavin
(b) Address 1802 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10th 1946 (month) (day) (year)
(c) Cemetery or crematory Morelands Memorial Park
Location Taylor Ave

18 (a) Funeral director Leo S. Leach
(b) Address 1781-83 N Patterson Park Ave

19 (a) (Date rec'd by registrar) (b) Washington Williams MD
SEP 9 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1946 at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1946 to 9/7 1946 and that I last saw her alive on 9/7 1946

Immediate cause of death: Cachexia — Duration: 4 mos.
Due to: Bone metastasis Rt. left femur — 17 days.
Due to: Ca of bowel
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. E. Gonzalez
Address Maryland Gen. Hosp. Date signed 9/7/46

G43572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Fayette St.
(c) Hospital or institution: Bon Secours Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., Md. (If outside city or town limits, write RURAL and give town) 7
(d) Street No. 857 University Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert J. Brisette. BRISSETTE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Isabella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/94

8. AGE: Years	Months	Days	If less than one day
52	6	25 24	hr. min.

9. Birthplace N.Y. N.Y. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Luigi Brisotti

13. Birthplace Canada

MOTHER 14. Maiden name Isabella Salley Lee

15. Birthplace Not Known

16 (a) Informant Mrs Carl Vorhis

(b) Address Syracuse N.Y.

17 (a) Burial Bayside (Burial, cremation, or removal) (b) Date thereof 9/10/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Grove

Location Balto Md

18 (a) Funeral director Guy E. Talley

(b) Address Fulton & Fayette

9/10 1946 Huntington Williams, M.D. (Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946, at 2:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1946 to 9-9 1946.
and that I last saw him alive on 9-9 1946.

Immediate cause of death Uremia
Resp. failure

Due to CV-Renal disease

Due to

Other Conditions Retinal hemorrhage.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Markley, M.D.

Address Bon Secours Hosp. Date signed 9-9-46

X

G43573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

13B G43573

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 E. Federal St Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 8 mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME GEORGIA PAULINE WOOD

If U. S. Veteran specify WAR

(a) Residence: No. 2308 E. Federal St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (Write the word)
Female	White	Widowed

5a. If married, widowed, or divorced (or) WIFE of Nicholas S. Wood

6. DATE OF BIRTH (month, day, year) May 1, 1877

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Carroll Co. Maryland

FATHER

13. NAME John K. Shipley

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Rachel A. Dixon

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Mr. Albert Shipley
(Address) Mt. Airy, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Pine Grove Cemty Date 9-11 19 46

19. UNDERTAKER C. M. Waltz
(Address) Winfield, Md.

SEP 10 1946 19

(Signature) Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) SEPT. 7, 1946

22. I HEREBY CERTIFY, That I attended deceased from 8-24-46 19 to 9-7-46 19

I last saw h[illegible] alive on 9-7-46 19 Death is said to have occurred on the date stated above, at 8:30 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary hemorrhage	8-24-46
Pulmonary tuberculosis	

Other contributory causes of importance:
Hypertensive cardio-vascular disease

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) Max Baum M. D.

(Address) 1501 N Milton Ave.

X

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G43574 Hollins Mill G43574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Aldwood & Belvedere.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural - Sykesville Rd.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hollins Will

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife: John Will deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1894

8. AGE: Years	Months	Days	If less than one day
52	0	18	hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jesse Bair
13. Birthplace Maryland

MOTHER 14. Maiden Name Jennie Aldridge
15. Birthplace Maryland

16 (a) Informant Mrs. Esther Miller
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-46 (month) (day) (year)

(c) Cemetery Messiah Lutheran
Location Berrett, Carroll Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

19 9-10-1946 (Date filed by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/46 19 , at 12:48 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3/46 19 to 9/7/46 19 and that I last saw h[illegible] alive on 9/7 19 46

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Burn of 20% body surface, 1st & 2nd	
Due to Of which was 3rd degree - remainder 2nd degree	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Large clots

of autopsy Burns, thrombophlebitis, thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/3/46 at M
(c) Where did injury occur? Sykesville Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) . While at work? Yes
(e) Means of injury Burn by gasoline

23. Signature Joseph L. Fisher, M.D.
Address Univ. Hosp. Date signed 9/9/46

for Dr. Julius R. Davis, by Howard D. Mansell, M.D. X

G43575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 E. Preston St
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Wilkinson Mainster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1857

8. AGE: Years	Months	Days	If less than one day
88	9	8	hr. min.

9. Birthplace Howard Co. Md.
(Town, county and state)

10. Usual Occupation Retired Teacher

11. Industry or business Balto. City Schools

FATHER
12. Name Samuel Mainster
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Turner
15. Birthplace Scotland

16 (a) Informant L. Bond Evans
(b) Address 900 E. Preston St.

17 (a) Burial (b) Date thereof 9/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 10 1946 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1946, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Sept. 7 1946 and that I last saw deceased alive on Sept. 4 1946;

Immediate cause of death	Duration
1) Cirrhosis - Selerosis Heart Disease with	5 yrs. 2 6 months
Due to (2) Chronic Nephritis	
Due to	
Other Conditions - Cerebral Hemorrhage	1 yr.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: -

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lyle F. Chambers M.D.
Address 4108 Liberty Hts. Date signed 9/9/46

VS 150

G435576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G435576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 W. Lexington St
(c) Hospital or institution:
Aged Mens + Womens Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert E. Cullum

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17 1880

8. AGE: Years	Months	Days	If less than one day
66	7	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Nelson E. Cullum
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Mahler
15. Birthplace Md.

16 (a) Informant Records.
(b) Address

17 (a) Burial (b) Date thereof 9/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 212 St Paul St

19 (a) SEP 10 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/ 1942 to 9/8/ 1946, and that I last saw h[illegible] alive on 9/7/ 1946

Immediate cause of death: Coronary occlusion — Duration: sudden

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin B Jones M. D.
Address 11 E. Chase St., Date signed

VS 150

G43577 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G43577

HD # #104200

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Laurens St. (or location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Putty (Fanny)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	New Born

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1946

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (City or town) (State or foreign country)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Russell Putty
13. Birthplace Md.

MOTHER
14. Maiden Name Fanny Carroll
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/6/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 SEP 10 1946 Huntington Williams, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1946, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2, 1946 to Sept. 2, 1946 and that I last saw h[illegible] alive on Sept. 2, 1946

Immediate cause of death: Prematurity — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto. City Hosp. Date signed Sept 6 46

G43578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G43578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1321 W. FAYETTE ST.
(c) Hospital or institution: 1321 W. FAYETTE ST.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE CITY
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 W. FAYETTE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WALTER ELLERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 9 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 10 1946 Huntington Williams M.D.
(Date accepted by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946, at 10. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1946, to 19 , and that I last saw him alive on August 25 1946

Immediate cause of death: CONGESTIVE HEART FAILURE — Duration: 3 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St Date signed 8/29/46

G43579

JL - 80236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G43579 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 5 - 15
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

26-12

2. USUAL RESIDENCE OF DECEASED:
(a) State Marylehd (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. NO Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Mohr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
75 ?	?	?	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adam Mohr
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 9 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 10 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1946, at 12:50 P

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 8 1946, to Aug. 23 1946 and that I last saw h im alive on Aug. 23 1946.

Immediate cause of death: Hemorrhage from anaphylactoid reaction — Duration: 2 days

Due to: Lacunes Cirrhosis — Duration: 10 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Rowell Huffman M. D.
Address Balt City Hosp Date signed 27 Aug 47

G43580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G43580 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital Dis
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dis
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Sutton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 9 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 10 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1946, at 12 noon P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h/2 death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Subinski M.D.
Medical Examiner.
Date signed 8/20/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G43581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mon. Dist. Rutland Ave
(c) Hospital or institution: Sinai Home 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Chayt

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-6224

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Ida Chayt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Aaron —
13. Birthplace Russia

MOTHER
14. Maiden Name Leah —
15. Birthplace Russia

16 (a) Informant Leah Chayt
(b) Address 2306 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-46 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Woodlawn

18 (a) Funeral director Jacob Levin Inc
(b) Address 1739 E. Balto. St

19 (a) Date SEP 10 1946 (b) Licensed Embalmer Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/ 1946 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1946 to 9/9 1946 and that I last saw h[illegible] alive on 9/9 1946

Immediate cause of death	Duration
Hypostatic pneumonia	
Myocardial insufficiency	
Due to Coronary occlusion	
Due to Coronary occlusion	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Bergsinger

Address Sinai Hospital Date signed 9/9/46

X

G43582
397349

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

G43582
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town Manchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Mill Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vivian Bonczek Vivian M. Bonczek

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-32

8. AGE: Years 14 | Months 4 | Days 21 | If less than one day: hr. min.

9. Birthplace Connecticut Manchester (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name John Bonczek
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Berk
15. Birthplace Poland

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/10/46 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem
Location Manchester, Conn.
18 (a) Funeral director M.H.E. Dippold Son
(b) Address Lombard & 400 St.
19 (Registrar's signature) SEP 10 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1946, at 4 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1946 to 9-9 1946, and that I last saw h alive on 9-9 1946

Immediate cause of death: Shock — Duration: 2 hrs.
Due to: Operation for — Duration:
Due to: Pulmonary Stenosis — Duration: Life
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-9-46
Major findings of operation: Pulmonary Stenosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. S. Monson
Address JHH Date signed 9-9-46

VS 150

G43583 AF 106084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

Registered No. G43583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Brady

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-?-73 or 9/1/73

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	?	?		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sam Brady
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Balto Co

18 (a) Funeral director Thos Geo H Holland
(b) Address 1631 Druid Hill Ave

19 (a) [illegible] (b) Huntingtown Anne Arundel, Md. Registrar

SEP 10 1946

VS 180

MEDICAL CERTIFICATION AM

20. DATE OF DEATH September 9- 1946, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 9-9 1946, and that I last saw h 97 alive on 9-9 1946.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Gangrene, leg	2 wks ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-6-46
Major findings of operation: Gangrene, leg
of autopsy: & above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J O'Neill
Address Balto City Hosp Date signed 9-9-46 M. D.

X

G43584 BCd 53842 BALTIMORE CITY HEALTH DEPARTMENT G43584
CERTIFICATE OF DEATH ✓119a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 W. Monument St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wiley Lee Pritchett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: none

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) August 6, 1946

8. AGE: Years | Months: 1 | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Doris Lee Pritchett
15. Birthplace ?

16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp.

17 (a) Burial (b) Date thereof 9/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) (Registrar) (Address)
SEP 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1946 at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Sept 9 1946 and that I last saw him alive on Sept. 9 1946.

Immediate cause of death: Diarrhea & enteritis — Duration: 13 days

Due to: non-specific cause

Due to:

Other Conditions: Malnutrition
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold O. Soper M. D.
Address Union Memorial Hospital Sept 9 1946

VS-150

G43585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43585
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Mosher St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Mae Woodall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Robert Woodall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1875

8. AGE: Years 71 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

FATHER
12. Name John M. Cord
13. Birthplace N.C.

MOTHER
14. Maiden Name Sarah M. Cruzen
15. Birthplace N.C.

16 (a) Informant Mr. Robert Early Woodall
(b) Address 1819 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frd. Ave, Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1960 Eutaw Place

19 SEP 10 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Sept. 1946, at 10:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, M.D.
Medical Examiner.
Date signed 8 Sept. 46

VS 151

X

G43586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43586 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bellona Ave.
(c) Hospital or institution: Edgewood Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4500 Maine Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Annie Josephine Ridgely

3 (b) If veteran, name war:
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1862

8. AGE: Years	Months	Days	If less than one day
83	11	14	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Clay Ridgely
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Ellen Jean
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Esther R. George
(b) Address 502 Baltimore Ave., Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery Greenmount
Location Greenmount & North Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 10 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1946 to Sept 8 1946 and that I last saw h[illegible] alive on Sept 8 1946

Immediate cause of death: Chronic Myocarditis — Duration 4 yrs
Due to:
Due to:
Other Conditions: Arterio-Sclerosis, Chronic Nephritis — Duration 10 yrs
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature H. Rich, M.D.
Address 112 W. 25th St. Date signed 9/8/46

VS

X

LAVAUGHN BUSHEE

G43587.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43587. Registered No. 1362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex - Baltimore 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 B Byway North Riverdale Apts
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bushee, La Vaughn
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles A. Bushee
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 13-1908

8. AGE: Years	Months	Days	If less than one day
38	7	24	hr. min.

9. Birthplace Crowder Oklahoma (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Sullivan Kitchen
13. Birthplace Oklahoma

MOTHER
14. Maiden Name Alfa —
15. Birthplace Oklahoma

16 (a) Informant Charles A. Bushee
(b) Address Riverdale Apts. Essex, Balto 21

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 10-1946 (Month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 2631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 10 1946 Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1946 to Sept 7 1946, and that I last saw her alive on Sept. 7 1946

	Duration
Immediate cause of death: Right Heart Failure	18 hrs
Due to Cor Pulmonale	2 yrs
Due to Old Pulmonary Tuberculosis -	8 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Southwick
Address Franklin Sq. Hosp. Date signed 9/7/46

G43588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43588 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3827 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3827 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Phebe C. Ambrose

3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife William T. Ambrose
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 5 1861
8. AGE: Years 85 Months 5 Days 3 If less than one day hr. min.
9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Samuel T. Cox
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Porter
15. Birthplace Maryland

16 (a) Informant Walter P. Ambrose
(b) Address 3851 Roland Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11 1946 (month) (day) (year)
(c) Cemetery or crematory Dulaney Baptist
Location Baltimore Co. Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3431 Falls Road
19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

SEP 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1946, to Sept 8 1946 and that I last saw her alive on Sept 8 1946.

Immediate cause of death: Cardiac decompensation — Duration 2 mos.
Due to: Cardio-vascular renal disease — 10 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Dulaney
Address 526 W 36 St. Date signed 9/9/46

G43589

AB-104336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals called 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 239 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife Rufus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23- 1900

8. AGE: Years 46 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace A.A. Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Forrester
13. Birthplace A.A. Co., Md

MOTHER
14. Maiden Name Amanda Simms
15. Birthplace Washington, D.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10. 1946 (month) (day) (year)
(c) Cemetery or crematory Joppa Md
Location

18 (a) Funeral director Elson O. Wilson
(b) Address 1000 Brantly ave

19 (a) (Date rec'd by registrar) (b) Huntington Ave Baltimore Md

SEP 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1946, at 9.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1946 to 9-6 1946, and that I last saw her alive on 9-6- 1946.

Immediate cause of death — Duration

Respiratory Failure
Due to Cerebral Hemorrhage
Due to Hypertensive C.V.D.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry L. Beacham M.D.
Address Balto City Hosp Date signed Sept 46

1 BG# G43590 $40746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

Registered No. G43590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division 18
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) friday
(e) Length of stay in Baltimore (yrs., mos., or days) 7 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Bennett Pl (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lantha Lee ✓

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1946

8. AGE: Years | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

MOTHER / FATHER
12. Name George E. Lee
13. Birthplace Md.
14. Maiden Name Irene Sterling
15. Birthplace Md

16 (a) Informant George E. Lee
(b) Address 909 Bennett Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy J. Wilson
(b) Address 1000 Brentley Ave

19 (a) (Date received by registrar) (b) Registrar
SEP 10 1946 Lexington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1946 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1946, to 9-7 1946, and that I last saw her alive on 9-7 1946.

Immediate cause of death Dehydration and Malnutrition — Duration 1-2 weeks

Due to Vomiting and diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Fuseman M. D.
Address Provident Hosp. Date signed 9-9-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 G43591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G43591 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Greene Aves.
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Parish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Blackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Handyman

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Ella Waters

(b) Address 817 Parish St

17 (a) Burial (b) Date thereof 9/10/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Brentwood Ave

19 (a) (b) Registrar
(Date rec'd by registrar)

SEP 10 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1946, at 9P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/28 19 46 to 9/6 19 46 and that I last saw h[illegible] alive on 9/6 19 46

Immediate cause of death

Coronary Thrombosis

Due to Arteriosclerotic Insanity

Due to

Other Conditions B.C.F.

Related Incidental Inv. Hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Arteriosclerosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D Sachs M.D.

Address Union Hospital Date signed 9/5/46

G43592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

G43592 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5801 Radecke Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5801 Radecke Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM F. CHRIST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Barbara Christ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1863

8. AGE: Years	Months	Days	If less than one day
82	11	20	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Truck Farmer
11. Industry or business Farm

FATHER
12. Name John Christ
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. John L. Koppelman
(b) Address 5801 Radecke Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Luth.
Location Baltimore, Md.

18 (a) Funeral director Lasseter Funeral Home
(b) Address 7401 Belair Road

19 SEP 10 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th, 1946, at 9:57 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 12 1943, to Sept 8 1946, and that I last saw deceased alive on Sept 8 1946.

Immediate cause of death Carcinoma of Colon — Duration 4 yrs

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation Colostomy August 10, 1946

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hans Lachman, M.D.
Address 7500 Belair Rd Date signed Sept 9, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

499019 G43593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
52B

G43593 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town Fairbanks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Cummings

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 4-12-87

8. AGE: Years	Months	Days	If less than one day
59	4	28	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Oyster Inspector
11. Industry or business

FATHER 12. Name George A Cummings
13. Birthplace Md.

MOTHER 14. Maiden Name Netta Auman
15. Birthplace Md.

16 (a) Informant Reenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory Dulaman Md.
Location Dulaman Md.

18 (a) Funeral director J. Frazier Marshall
(b) Address Easton Md.

19 (a) SEP 10 1946 (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept 10 1946 at 4.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1946, to 9-10 1946, and that I last saw h alive on 9-10 1946.

Immediate cause of death Uremia, acidosis — Duration 6 mos.

Due to urinary obstruction and renal damage

Due to Carcinoma of the bladder with local extension.

Other Conditions Implantation of stone.

(Include pregnancy within 3 months of death)
Date of operation March 1946,
Major findings of operation: Ureteroneocystostomy
Carcinoma extended beyond confines of bladder. Essentially as above.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Brendler, M.D.
Address J H H Date signed 9/10/46

X

G43594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G43594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Bolton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIA G. HUNT

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John Henry Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1859

8. AGE: Years	Months	Days	If less than one day
87	7	8 9	hr. min.

9. Birthplace West River, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. Peake
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Margaret Gardner
15. Birthplace A. A. Co.

16 (a) Informant Mr. J. Roland Hunt
(b) Address 4409 N. Charles St.

17 (a) Burial (b) Date thereof 9/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date filed by registrar) Registrar

SEP 10 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946 at 6:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1946 to Sept 8 1946, and that I last saw her alive on Sept 8 1946.

Immediate cause of death Cerebral Hemorrhage. — Duration 3 days

Due to Arteriosclerosis — 20 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury ARTHUR J. DAVIES

23. Signature Arthur J. Davies M. D.
Address 800 N 32nd St Date signed 9-9-46

X

G43595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 59 days
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles + 39th Sts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Roberta Lee Ball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1861

8. AGE: Years	Months	Days	If less than one day
85	2	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Nurse - Retired Supt.

11. Industry or business Union Memorial Hosp.

FATHER
12. Name Philip R. Ball (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Howard Latimer
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Union Memorial, 33rd + Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 10 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sept 1946, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Sept. 9 1946, and that I last saw h.r. alive on Sept. 9 1946.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Myocardial Infarction	
Due to Arterio sclerotic cardiovascular disease & coronary occlusion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: 9/9/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. V. Lucke M.D. M.D.
Address UMH Date signed 9/9/46

X

G43596 — BALTIMORE CITY HEALTH DEPARTMENT — G43596

CERTIFICATE OF DEATH 1937

File No. 104275 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

9-4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN C. STRAIN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Louise T. Strain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17/1879

8. AGE: Years	Months	Days	If less than one day
67	1	22	hr. min.

9. Birthplace Delaware (Wilmington) (Town, county, and state)
10. Usual Occupation Upholsterer
11. Industry or business Self

FATHER — 12. Name David Strain
13. Birthplace Delaware

MOTHER — 14. Maiden Name Catherine Draper
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 10 1946 (Date rec'd by registrar) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Sept 9/1946 19 , at 7.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1/1946 to Sept 9/ 1946 and that I last saw him alive on Sept 9/46 19 .

Immediate cause of death: Coronary Occlusion — Duration 8 days
Due to: Hypertensive Cardio-vascular disease — Duration 3 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature C. Rowell Hoffmeyer M. D.
Address Baltimore City Hosp Date signed 9 Sept 1946

X

G43597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43597

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE ANNA CAMPBELL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	no	Female	White	Widow

6 (b) Name of husband or wife Michael Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1884

8. AGE: Years	Months	Days	If less than one day
62	6	17	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business Balto. City

FATHER
12. Name George Frances Allen
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name -- Brooks
15. Birthplace Balto., Md.

16 (a) Informant Mr. Harry L. Allen, Sr.
(b) Address 838 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19 (a) SEP 10 1946 (Date rec'd by registrar) (b) Registrar Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946, at 7:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2 1946 to 9-9 1946, and that I last saw h- alive on 9-7 1946

Immediate cause of death
Cerebral Arteriosclerosis
Cerebral Arteriosclerosis
Due to Arteriosclerotic Heart Disease

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

Duration
?
? Yrs.
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos Coleman M.D.
M. D.
Address 1201 Poplar Grove St Date signed 9-9-46

X

a50855 G43598 BC# D49351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1194

G43598 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 S Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbert C. McMickins ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-13-46

8. AGE: Years	Months	Days	If less than one day
	3 2	2 5	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name Clarence McMickins
	13. Birthplace Ala.
MOTHER	14. Maiden Name Dorothy Rinehart
	15. Birthplace Pa.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1946 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Catonsville Md

18 (a) Funeral director Joseph Deppel
(b) Address 1140 Hollins St

SEP 10 1946 (Date rec'd by registrar) (b) Lexington Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-8- 1946 at 9 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7- 1946 to 9-8- 1946 and that I last saw h alive on 9-8- 1946.

Immediate cause of death Acute Meningitis Duration
with Diarrhea 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Demetrios G Sogeos M. D.
Address Johns Hopkins Hospital Date signed 9/9/46

VS 150

G43599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G43599

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2840 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2840 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Nunnally

3 (b) If veteran, name war ###

3 (c) Social Security Account No. ###

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Andrew H. Nunnally

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/1888

8. AGE: Years	Months	Days	If less than one day
58		6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Hswk

11. Industry or business

FATHER
12. Name Richard W. Bittner
13. Birthplace Germany

MOTHER
14. Maiden Name Claudia Stumpf
15. Birthplace Germany

16 (a) Informant Mrs. Anna Sheeder (daughter)
(b) Address 2840 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1318 Light St

19 (Date received) SEP 10 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/46 19 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 46 to Sept 1 19 46 and that I last saw ... alive on Sept 1, 19 46.

Immediate cause of death Coronary Thrombosis

with generalized Arteriosclerosis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Friedman, M.D.

Address 1319 Light St. Date signed 9/9/46

VS 150

G43600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43600
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 N. Patrick St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Norris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 - 1873

8. AGE: Years	Months	Days	If less than one day
72	10	24	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Norris
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel Clark
15. Birthplace Md

16 (a) Informant James Owens
(b) Address 1003 Patrick St.

17 (a) Burial (b) Date thereof 9/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pressman St.

19 (b) 10 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1946 at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/8/46

Children age is especially important. Physicians: please write the causes of death clearly and legibly.

G43601 ✓ G43601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Brunt St
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Parker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Isaac Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Richmond Va
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Jos Bailey
(b) Address 1703 Baunt St

17 (a) Burial (b) Date thereof 9-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location Balto Md

18 (a) Funeral director Joseph G. Nelson
(b) Address 1313 Pennsylvania Ave
19 (a) 1946 (b) Huntington Williams M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1946, at 7:29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1946 to Sept 8 1946
and that I last saw him alive on Aug 7 1946

Immediate cause of death: Acute pericarditis
Antecedent causes: Uremic Nephritis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Stewart M.D.
Address 630 Hamburg St Date signed 9/10/46

VS 150

G43602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G43602 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 E. 20th street
(c) Hospital or institution:
9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 E. 20th street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME HENRY J. MULLER

3 (b) If veteran, name war: No
3 (c) Social Security Account No. ---

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1866

8. AGE: Years 80 | Months 2 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jacob Muller
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Broening
15. Birthplace Germany

16 (a) Informant Miss Annie Burton
(b) Address 504 E. 20th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 118 N. Mt. Royal Ave

19 (a) (Date rec'd by registrar) SEP 10 1946 Registrar Huntington Williamsville, Md.

MEDICAL CERTIFICATION

28. DATE OF DEATH Sept. 8, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1946 to Sept 8 1946, and that I last saw h[illegible] alive on Sept 8 1946

Immediate cause of death Known cause

Duration Aug 22 to Sept 8

Due to

Due to

Other Conditions Cause unknown

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1002 Cathedral Bldg. Date signed 9-9-46

X

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G43603

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Buchannon, W. Va. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Page

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER — 12. Name Bryce Hamner; 13. Birthplace Virginia

MOTHER — 14. Maiden Name Martha Jones; 15. Birthplace Virginia

16 (a) Informant Mrs. Clara Page

(b) Address Above

17 (a) Removal (burial, cremation, or removal) (b) Date thereof Sept 10/46 (month) (day) (year)

(c) Cemetery or crematory Buckhannon Int.

Location Buckhannon W. Va.

18 (a) Funeral director Philip Harris Sons

(b) Address 2024 Eutaw St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 10 1946 Huntington Williams, M.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1946, at 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 9-10 1946, and that I last saw h(er) alive on 9-10-1946.

Immediate cause of death Coronary occlusion — Duration

Due to Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lloyd Thompson M.D. M. D.

Address Univ. Hosp. Date signed

X

G43604 BALTIMORE CITY HEALTH DEPARTMENT G43604
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland aboard ship
(b) Street address "Normasmoon"
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town The Bronx 59.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 962 Southern Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Weingarten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Sngl

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3. 1924

8. AGE: Years 21 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace New York N. Y.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Hospital

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/10/46 (month) (day) (year)

(c) Cemetery or crematory New York

Location New York N. Y.

18 (a) Funeral director Williams Co Inc

(b) Address 1217 Park Ave

(c) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6- 1946, at M

21. I certify that I took charge of the remains described above, held an inquest, thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Thorndike M.D.
Medical Examiner.
Date signed 9-10-46

FEB 10 1946

VS 191

The age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43605
Th. 15685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered G43605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3- 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

26-12

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M. Crist

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12/1855

8. AGE: Years	Months	Days	If less than one day
90	8	28 27	hr. min.

9. Birthplace Hagerstown, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name David Crist
13. Birthplace Maryland

MOTHER 14. Maiden Name Henriette Odden
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.11/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O,Donnell St.

18 (a) Funeral director John A.Miller
(b) Address 2334 Jefferson St.

19 (a) (Date received by Registrar) (b) Registrar

SEP 10 1946
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8/1946 19 at 10.25 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6/1952 to Sept 8 19 46 and that I last saw h alive on 9/8/46 19

Immediate cause of death: Bronchopneumonia — Duration: 2 Wks
Due to Bronchiectasis bilateral — 4 yrs +
Due to Generalized arteriosclerosis — 30 yrs ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. O'Neill
Address Balto City Hospitals Date signed 9-9-46 M. D.

G43606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G43606

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 W. Garrison
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 W. Garrison (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert L. Keesey

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-7806

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1884

8. AGE: Years	Months	Days	If less than one day
61	9	4	hr. min.

9. Birthplace Stewartstown Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business Post Office

FATHER
12. Name J. Wilson Keesey
13. Birthplace Stewartstown Pa.

MOTHER
14. Maiden Name Effie Hyson
15. Birthplace Stewartstown Pa.

16 (a) Informant Mrs. Robert L. Keesey
(b) Address 3808 W. Garrison Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Cemetery or crematory Presbyterian Cem.
Location Stewartstown, Pa.

18 (a) Funeral director Loring Biggs
(b) Address 5605 York Rd Md

19 SEP 10 1946 Huntington Williams (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1946 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1946 to Sept 10 1946 and that I last saw him alive on Sept 10 1946.

Immediate cause of death	Duration
Coronary Thrombosis	5 days
Due to Coronary Sclerosis	
Due to	
Other Conditions Cholecystitis	30 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry M. Stantz M. D.
Address 2601 Manhattan Ave Date signed 9/10/46

X

Gilbert

G43607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered G43607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs 10 mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 West 40th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Franklin Scott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10-1887

8. AGE: Years	Months	Days	If less than one day
59	6	29	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James S. Gilbert.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Emma J. Kaufman.
15. Birthplace Maryland.

16 (a) Informant Home For Incurables Records.
(b) Address 700 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Harry N. Armacost
(b) Address 4204 Ridgewood Ave

19 (a) (b) (Filled in by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1946, at 1:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1946 to 9/9 1946, and that I last saw h alive on 9/8 1946.

Immediate cause of death	Duration
Pulmonary Congestion	1 week
← Bronchopneumonia	
Due to Hydrocephalus	Life
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Harper M.D.
Address 214 Medical Arts Bldg. Date signed 9/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GT3608 BC# a34409 F90652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15-7E GT3608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Page Zimmerman - 3rd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-43

8. AGE: Years	Months	Days	If less than one day
2	9	2	hr. – min.

9. Birthplace Md. (Baltimore)
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name William Zimmerman Jr

13. Birthplace Md., Baltimore

MOTHER — 14. Maiden Name Doris Long

15. Birthplace Md. Baltimore Co

16 (a) Informant William Page Zimmerman

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal Burial (b) Date thereof Sept 11 1946 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery
Location Rod Canyon, Balto Co Md.

18 (a) Funeral director E. Killian Lamotgrave

(b) Address 4410 Liberty Heights Ave

19 (a) Filed 1946 (b) Registered by registrar Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 9 - 1946 at 2 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1946 to 9-9- 1946 and that I last saw h. alive on 9-9- 1946

Immediate cause of death Cardiac failure — Duration

Due to Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Demetrius D. Jaggas

Address Johns Hopkins Hosp Date signed 9/9/46

VS 150

G43609 ✓ G43609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city limits, write the name of the county also)
(d) Street No. 1700 Valley Street (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George Ruppert
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife Mary Allender
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 25, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	15	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Ruppert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Sleathle
15. Birthplace Germany.

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11 1946 (Month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Randallstown Md.

18 (a) Funeral director E Gill Lawrence
(b) Address 1510 Liberty Heights Ave

19 (a) SEP 10 1946 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 — 1946, at 7-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 — 1946, to Sept 8 1946, and that I last saw he[illegible] alive on Sept 7 — 1946.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North av Date signed 9/9/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 1

G43610 ✓ G43610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Pennington Ave
(c) Hospital or institution: South Baltimore General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Theresa Horvat Horvath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1878

8. AGE: Years	Months	Days	If less than one day
68 74			hr. min.

9. Birthplace Europe
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Sophie GARPSTAS
(b) Address 4314 Curtis Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 12-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anundel County

18 (a) Funeral director Joseph Kassabaum
(b) [illegible] Washington Blvd

19 (a) [illegible] Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1946, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946, to Sept 8 1946, and that I last saw h[illegible] alive on Sept 8 1946.

Immediate cause of death	Duration
Cardiac Insufficiency	
Due to Rt Lobar Pneumonia	
Due to	
Other Conditions Acute Nephritis Syndrome	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature H O Eareckson, Jr.
Address 30 Bolton St Balto Md Date signed 9/9/46

(over)

G43611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G43611 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 E. Payson St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John [illegible] A Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Olamae (McDonald)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1900

8. AGE: Years 46 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business New Howard Hotel

FATHER
12. Name — Smith
13. Birthplace Florida

MOTHER
14. Maiden Name —
15. Birthplace Florida

16 (a) Informant Mrs Olamae Smith
(b) Address 430 E. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/1946 (mo.) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wright
(b) Address 4101 Elsinore Ave

19 (a) (b) Huntington Williams

SEP 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Sept. 1946 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer Jr. M.D. Medical Examiner.

Date signed 9 Sept. 46

G43612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 51c

G43612 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2545 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2545 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Henry Ripke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dolores Elaine nee Sohn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1916

8. AGE: Years	Months	Days	If less than one day
30	-	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Proprietor
11. Industry or business Confectionery Store

FATHER
12. Name Henry Ripke
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Yingling
15. Birthplace Md.

16 (a) Informant Mrs. Dolores E. Ripke
(b) Address 2545 Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Meitzler
(b) Address 4101 Edmondson Ave.

19 (a) SEP 10 1946 (b) Huntington Mills

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946 at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1946 to 9/8 1946 and that I last saw him alive on 9/7 1946.

Immediate cause of death CARDIAC FAILURE — Duration

Due to METASTATIC CARCINOMA

Due to Seminoma of Testicle.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar F. Hillenbrand M. D.
Address 3325 Park Ave. Balto 17 Date signed 9/10/46

VS 150

G43613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G43613 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Blackstone Apts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eugenia Co[illegible] Willig

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 30 September 1880

8. AGE: Years 65 | Months 11 | Days 10 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Willig
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Lohrfink
15. Birthplace Germany

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. City.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (U. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) [illegible] Registrar
SEP 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 September 1946, at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 June 1946, to 9 Sept 1946, and that I last saw her alive on 9 Sept 1946

Immediate cause of death: Metastatic carcinoma — Duration:
Due to: Carcinoma of bladder.
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: April 27, 1945
Major findings of operation: Metastatic carcinoma from bladder.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. R. McShane M. D.
Address Date signed

Huntington Williams, MD

J. R. McShane

G43614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G43614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Linday Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSLYN LORRAINE NAVIASKY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1929

8. AGE: Years	Months	Days	If less than one day
17			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Joseph Navarsky
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna
15. Birthplace Balto Md

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory Beth Israel
Location Wrightsville Pike

18 (a) Funeral director Jack Levin Co
(b) Address 1439 E Baltimore St.

19 SEP 10 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1946, at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1946 to 9-10 1946 and that I last saw her alive on 9-10 1946

Immediate cause of death: Acute myelogenous Leukemia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Sinai Hospital Date signed 9-10-46

VS 150

G43615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G43615
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Dundalk, Md. 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Ventnor Terrace
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Mae Mullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Mr. Mae Mullen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1884

8. AGE: Years	Months	Days	If less than one day
62	10	21	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Samuel Poole.
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Toombs
15. Birthplace Va

16 (a) Informant deceased.
(b) Address see above

17 (a) Removal (b) Date thereof Sept 11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Fredericksburg Va

18 (a) Funeral director Wilmer Funeral Home
(b) Address 2008 Orleans St.

19 (a) Huntington Williams M.D.
(Date received by registrar) (Registrar)

SEP 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1946 to 9/10 1946, and that I last saw her alive on 9/10 1946.

Immediate cause of death Coronary occlusion & Left Pulmonary

Duration 2 days

Due to Emaciated condition from

Due to Resection of sigmoid for carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/5/46

Major findings of operation carcinoma of sigmoid.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Antonucci M.D.
Address Church Home & Hosp. Date signed 9/10/46

Vs 186

G43616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43616 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636- Cokesberry Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK ~~McCARTHY~~ Mc CARTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife AGATHA Mc CARTHY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 81 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation RETIRED FIREMAN.

11. Industry or business

FATHER
12. Name R. D. McCARTHY
13. Birthplace VA.

MOTHER
14. Maiden Name VIRGINIA WALKER.
15. Birthplace BALTO., MD.

16 (a) Informant MRS. A. McCARTHY
(b) Address 636 COKESBURY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-11-46 (month) (day) (year)
(c) Cemetery or crematory ST. JAMES CEM.
Location LONG GREEN, BALTO., CO.

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREEN MOUNT AVE & 22ND ST.

SEP 10 1946
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8-46 19 1.50 P. M. at

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: intracranial hemorrhage

Due to Fracture of skull

Other Conditions arteriosclerotic cardio vascular-renal disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 9/9
(a) Date of injury Sept. 6 at 7 P. M.
(b) Where did injury occur? St. Joseph's Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Fall from bed.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed Sept. 9, 1946

VS 191

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43617

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43617

CERTIFICATE OF DEATH 457

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Grace Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fem

5. Color or race: Wh

6 (a) Single, married, widowed, or divorced: Wid

6 (b) Name of husband or wife: Edward M Allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1871

8. AGE: Years 74 | Months 9 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name David E. Turner
13. Birthplace Md

MOTHER
14. Maiden Name Phoebe Webster Virginia Davis
15. Birthplace Md

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11 1946 (month) (day) (year)

(c) Cemetery or crematory Darlington
Location Darlington, Md

18 (a) Funeral director Henry W Jenkins & Son
(b) Address McCulloh & Orchard Sts

19 9 11 1946 Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946, at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Sept 9 1946, and that I last saw h.e.r. alive on 9-9-46 19

Immediate cause of death: Carcinoma of mandible, ct — Duration 8 mo ct

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kirkpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 9-9-46

VS 150

G43618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G43618 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Seven Mile Lane (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas Harry Ruppert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 5, 1946

8. AGE: Years	Months	Days	If less than one day
		1	10 hr. min.

9. Birthplace Pikesville, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Walter Maxtin Ruppert
13. Birthplace New Jersey

MOTHER
14. Maiden Name Annabelle Katherine
15. Birthplace Maryland Null

16 (a) Informant Hospital Records
(b) Address 33rd & Calvert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1946, at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1946, to Sept. 6 1946, and that I last saw h/ alive on Sept. 6 1946.

Immediate cause of death — Duration

Prematurity — 1½ days

Due to

Due to

Other Conditions Weight = 2 lb 10½ oz.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Mem. Hosp. Date signed 9-6-46

X

G43619 BC# G-55713 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 160a G43619 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 rd St.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs. 47 min.
(e) Length of stay in Baltimore (yrs., mos., or days) ..... m. ..... ft.

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State MD. (b) County MARYLAND.
(c) City or town MONKTON. (If outside city or town limits, write RURAL and give town)
(d) Street No. WESLEY CHAPEL ROAD. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME JOHN ROBERT LISTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 4, 1946

8. AGE: Years ..... Months ..... Days ..... If less than one day 17 hr. 47 min.

9. Birthplace BALTIMORE, MARYLAND. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name WILLIAM EDWARD LISTON, JR.

13. Birthplace MT. PLEASANT, PA.

MOTHER 14. Maiden Name MARY ALICE WELSH.

15. Birthplace BALTIMORE, MD.

16 (a) Informant WM. EDWARD LISTON, JR.
(b) Address MONKTON, MARYLAND.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (a) SEP 11 1946 (Date rec'd by registrar) Huntington Williams, M.D. Address Union Memorial Hosp. Date signed Sept 6, 46

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 5, 1946, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 4, 1946. to SEPT 5 1946 and that I last saw him alive on SEPT 5 1946.

Immediate cause of death ..... Duration

INTRA CRANIAL HEMORRHAGE 17 hrs.

Due to .....

Due to .....

Other Conditions ATALECTASIS PREMATURITY

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

ATALECTASIS

of autopsy: INTRACRANIAL HEMARRHAGES

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature H. Conkie Gibson M.D.
Address Union Memorial Hosp. Date signed Sept 6, 46

G43620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G43620

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write t

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 9
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Ellicott Dr. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Yingling = Collison

3 (b) If veteran, name war —
(c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Vernon Yingling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1892

8. AGE: Years 54 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Joseph Riley
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Moore
15. Birthplace Balto Md

16 (a) Informant Henning Collison
(b) Address 3245 Monmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Baltimore Md

18 (a) Funeral director Philip Sperry Sons
(b) Address 2024 Eutaw St

19 (a) Date received SEP 11 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sept. 1946, at 4:9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Sept 1946 to 9 Sept 1946, and that I last saw her alive on 9 Sept 1946.

Immediate cause of death: Chronic nephritis uremia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Riley M.D.
Address Univ. Hosp. Date signed 9/9 M. D.

X

G43621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

Registered No. G43621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 349 Spring Court
(c) Hospital or institution: 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 349 Spring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cassie Kazmiera Markowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Steve

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1-1899

8. AGE: Years 47 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Nanticoke Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Julian Mankowski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia
15. Birthplace Poland

16 (a) Informant Stephen Markowski
(b) Address 349 Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date there Sept. 13-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Nanticoke Pa.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) SEP 11 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946, at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Sept. 10 1946, and that I last saw h e alive on Sept. 10 1946

Immediate cause of death	Duration
Acute Cardiac Dilatation	Instant
Due to Rheumatic Carditis	7 yrs.
Due to	
Other Conditions Rheumatic fever (Include pregnancy within 3 months of death)	9 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John V. Kazmierkiewicz M. D.
Address 1802 Eastern Ave Date signed 9-10-46

VS 180

X

F G43622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57

G43622 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W Hughes St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/2/1932

8. AGE: Years	Months	Days	If less than one day
14	1	5 2	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Hardy Smith
13. Birthplace S C

MOTHER 14. Maiden Name Dora Robinson
15. Birthplace Balto Md

16 (a) Informant Virginia Johnson
(b) Address 105 Hughes St

17 (a) Burial (b) Date thereof 9-11-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Co
Location Baltimore City

18 (a) Funeral director Daniel L Brown & Son
(b) Address 1017 W Monument St

19 SEP 11 1946 Hunting for Pollitzer, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1946, at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1946 to 9-7 1946, and that I last saw him alive on 9-7 1946

Immediate cause of death Medulloepithelioma

Due to Brain tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Brain tumor post 3rd ventricle

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E Crouch

Address University Hosp. Date signed 9-9-46 M. D.

VS 150

X

G43623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/92D

Registered No. G43623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 751 East 36th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 751 East 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian May Knight

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1865

8. AGE: Years	Months	Days	If less than one day
80	11	27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Librarian (Retired)
11. Industry or business Archbold Knox Co

FATHER
12. Name Charles Spence
13. Birthplace Md

MOTHER
14. Maiden Name Sarah E Pochelon
15. Birthplace Md

16 (a) Informant Wm Chew W Knight
(b) Address 751 East 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilbur Cook Inc
(b) Address 1717 Eutaw St

19 (a) (Date received by Local Registrar) SEP 11 1946 (b) Wilmington, Del. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1946, to Sept 9, 1946, and that I last saw her alive on Sept. 9, 1946.

Immediate cause of death	Duration
Acute Cardiac Dilitation	Immediate
Due to Myocarditis & Endocarditis	Unknown
Due to -------	
Other Conditions Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of
23. Signature Jos. W Fitzpatrick M.D.
Address 401 E. 25th. St Date signed 9/10/46

G43624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G43624 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 N. Gay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8+2
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THERESA SCHRUFFER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	F	W	Widowed

6 (b) Name of husband or wife John W. Schruffer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 25, 1858

8. AGE: Years	Months	Days	If less than one day
87 88	8	14	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nicholas Spahan
13. Birthplace Penna.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Fred Bau
(b) Address 3303 Batavia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 11 1946 Registrar

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH Sept. 8, 1946 at 12.35

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1946 to Sept. 8th 46. and that I last saw her alive on Sept. 6, 1946.

Immediate cause of death Uremia — Duration 2 days

Due to Chronic Interstitial Nephritis — unknown

Due to

Other Conditions Arteriosclerosis — unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 401 E. 25th. St. Date signed 9/10/46

VS 150

X

G43625 BC# D 50248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 127B

Registered No. G43625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREEN STS.
(c) Hospital or institution: UNIVERSITY HOSPITAL. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 CONOVER ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME KODAS BELVA ADAMS

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-46

8. AGE: Years — Months 2 Days 13 1/2 If less than one day hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation Baby.

11. Industry or business

FATHER
12. Name Henry Adams
13. Birthplace Long Branch N. J.

MOTHER
14. Maiden Name Francis Sledge
15. Birthplace Macon N. C.

16 (a) Informant Francis Adams
(b) Address 602 Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Cedar Hill Md.

18 (a) Funeral director A. Galiteak
(b) Address 918 Druid Hill Ave.

SEP 11 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1946, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1946, to 9-8 1946, and that I last saw her alive on 9-8 1946.

Immediate cause of death Biliary obstruction with
6-I hemorrhage — **Duration**

Due to Septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph B. Workman M. D.
Address University Hosp. Date signed 9-8-46

VS 150

X

G43626

291022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G43626 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 684 Josephine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Basil | 6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.) 3-1-06

8. AGE: Years 40 | Months 6 | Days 8 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER — 12. Name Jim Hackett; 13. Birthplace Md.

MOTHER — 14. Maiden Name Elaise Smothers; 15. Birthplace Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/46 (month) (day) (year)

(c) Cemetery Mt. Calvary Location Cedar Hill, Md.

18 (a) Funeral director A. Sabatini

(b) Address 918 Druid Hill

19 SEP 11 1946 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 9 - 1946, at 4 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 - 1946 to 9-9 - 1946 and that I last saw h.. alive on 9-9 - 1946

Immediate cause of death Shock - post operative. — Duration 24 hrs

Due to Cardio-vascular Collapse — 24 hrs

Due to Pulmonary edema

Other Conditions Jaundice

(Include pregnancy within 3 months of death)

Date of operation 9/7/46

Major findings of operation: Stones in gall bladder, ruptured gall bladder, acute suppurative cholangitis

Autopsy? Yes or No

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Nelson Lord, M.D.

Address The Johns Hopkins Hosp. Date signed 9/9/46

VS 150

G43627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G43627 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3209 Windsor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA EDWARDS STAUB

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1880

8. AGE: Years 66 | Months 7 | Days 22 | If less than one day: hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John F. Staub
13. Birthplace Martinsburg, W. Va.

MOTHER
14. Maiden Name Mary R. Blondell
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Miss M. Estelle Wilkinson
(b) Address 3209 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 Filed by registrar (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946, at 2:27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1943 to 9/9 1946 and that I last saw h[illegible] alive on 9/8 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 6 days.
Due to Hypertension — 7
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reite M. D.
Address 3408 Windsor Ave Date signed 9/10/46

X

G43628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1203

G43628
Registration No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynes Ave.
(c) Hospital or institution: West Baltimore Gen. Hosp. 15 S
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2047 Braddish Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RICHARD THOMAS GAULDING, III

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 219-14-1278

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Janet E. Gaulding (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.): Aug 23, 1925

8. AGE: Years	Months	Days	If less than one day
21	5	17	hr. min.

9. Birthplace: Richmond Va. (Town, county, and state)
10. Usual Occupation: Clerk - Treasury Dept.
11. Industry or business: U.S. Govt

FATHER
12. Name: R. Thomas Gaulding, II
13. Birthplace: Richmond, Va.

MOTHER
14. Maiden Name: Myrtle Andrews
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. R. Thomas Gaulding, III
(b) Address: 3233 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory: Arlington National
Location: Arlington, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Received by registrar (b) Registrar

Sept 11 1946 Huntington Williams, MD

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/46 19 ... at 6 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1946 to Sept 10 1946, and that I last saw him alive on Sept 10 1946.

Immediate cause of death: Toxemia — Duration: 8 mo.

Due to: Uterine Colitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Albert Gutmyer Jr. M. D.
Address: 3706 Randall Road Date signed 9/10/46

X

G43629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH V 131a

G43629

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 2538 Madison Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME James Henry Thomas 13-3

If U. S. Veteran specify WAR.

(a) Residence: No. 2538 Madison Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) 9/7/870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	1	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Waiter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Chas Co Md

FATHER

13. NAME —

14. BIRTHPLACE (city or town) (State or country) —

MOTHER

15. MAIDEN NAME —

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Mrs. Mary Richardson

(Address) 2422 Madison Ave.

18. BURIAL, CREMATION, OR REMOVAL Place [illegible] Date 9-14- 19 46

19. UNDERTAKER Mrs. Hes. H. Holland.

(Address) 1621 Druid Hill Ave.

FILED SEP 11 1946 19 Huntington Williams, M

Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 10, 1946

22. I HEREBY CERTIFY, That I attended deceased from Sept 1 1946 to Sept 1946

I last saw him alive on Sept 9 1946. Death is said to have occurred on the date stated above, 5 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	
Renal Disease	
Other contributory causes of importance:	
Arteriosclerosis	

Was an operation performed? Yes Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Hes H Holland M. D.

(Address) 1621 Druid Hill Ave

G43630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G43630 Registered No.

Write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709- W. Mosher Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Sheppard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Engraver

11. Industry or business

FATHER 12. Name Edw H. Sheppard

13. Birthplace Susquehanna, Md

MOTHER 14. Maiden Name Fannie Hamilton

15. Birthplace Smyrna, Del.

16 (a) Informant Louis Sheppard

(b) Address 709 Mosher

17 (a) V (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)

(c) Cemetery or crematory Balto, National

Location Balto, Md

18 (a) Funeral director Jno Geo H. Holland

(b) Address 1631 Edmond Hill Ave

19 (a) SEP 11 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946, at 12.30 P. M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Spontaneous
Left ventricular hemorrhage of brain
Fracture skull

Due to
Hemorrhage into right frontal lobe

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mackenzie M.D. Medical Examiner.
Date signed 9/9/46

X

G43631 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600a

G43631

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 1700 Monument St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 S Elwino St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin S. Duklewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8/46

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Melvin Duklewski
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Elizabeth Gabril
15. Birthplace Baltimore Md

16 (a) Informant Melvin Duklewski
(b) Address 314 Elwino St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Gorsuch Hill Rd

18 (a) Funeral director John J. Duda
(b) Address 2429 Woodbourne St

19 (a) (Date certified by registrar) (b) Registrar

SEP 11 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10th 1946, at 4:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 8th 1946, to Sept 10th 1946, and that I last saw h alive on 19

Immediate cause of death: Birth injuries

Due to intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Seamon M.D.
Address Sinai Hospital Date signed 9-10-46 M. D.

VS 150

X

G43632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43632 Registered No.

Ti. 104259

PRESS WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Edgemere Maryland (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Linkowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14/1889

8. AGE: Years	Months	Days	If less than one day
57	3	25	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stanley Linkowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Sophia ?
15. Birthplace Russia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Harmon Hill Rd

18 (a) Funeral director John F. Connelly
(b) Address 418 Eastern Ave Grp 21.

19 (a) (Signature of local registrar) (b) Huntington Hill

SEP 11 1946

VS 150

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH Sept 9/1946 19 , at 8 7.08

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4/1946 to Sept 9/19 , and that I last saw h. 1B alive on Sept 9/ 19 46.

Immediate cause of death	Duration
Myocardial Insufficiency	3 weeks
Due to Arteriosclerotic C.V. Disease	15 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as stated

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. R. [illegible] Hoffman M. D.
Address Baltimore City Hos. Date signed 10/9/46

X

G43633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 1647

G43633

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D&A.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Essex Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Rickenbacker Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Starnes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mozell nee Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1924

8. AGE: Years	Months	Days	If less than one day
21	9	29	hr. min.

9. Birthplace Knightdale N. Carolina
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Glenn L. Martin.

FATHER
12. Name Henry Starnes
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Unk.
15. Birthplace "

16 (a) Informant Mozell Starnes
(b) Address 1617 Rickenbacker Rd

17 (a) Removal (b) Date thereof 9/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Memorial Park.
Location N. Carolina

18 (a) Funeral director John J. Connelly
(b) Address 1819 Eastern Ave. Balto 31

19 (a) SEP 11 1946 (b) Thurston Williams M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1946, at 6 05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia by soft Strangulation
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/7/46 at about 2 PM.
(b) Where did injury occur? 1617 Rickenbacker Rd
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Hung self w rope

23. Signature C. H. Gutzinske M.D.
Medical Examiner.
Date signed 9/9/46

X

G43634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G43634
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Young Court.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Young Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius R. Mauf.
3 (b) If veteran, name war None.
3 (c) Social Security Account No.
4. Sex Male
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Beatrice
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) December 7, 1890
8. AGE: Years 55 Months 9 Days If less than one day min.
9. Birthplace Griffin Ga.
(Town, county, and state)
10. Usual Occupation Hunter
11. Industry or business

FATHER
12. Name Mack Mauf.
13. Birthplace Ga.

MOTHER
14. Maiden Name Annie Gospel.
15. Birthplace Ga.

16 (a) Informant Hattie Mauf Stone
(b) Address 1329 N. Carlton St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11 1946 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Robert L. Conway
(b) Address 216 N. Carey St.
19 (a) (Date rec'd by registrar) (b) Registrar

SEP 11 1946 Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7, 1946. at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1946 to Sept 7 1946. and that I last saw h[illegible] alive on Sept 5 1946.

Immediate cause of death: Acute coronary collapse — Duration 1 day
Due to: Aneurysm of aorta — Duration unknown
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature G. C. Burrell M. D.
Address 1 VI August Date signed 9-10-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered G43635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Pleasant Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK DOUGLAS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	B	M

6 (b) Name of husband or wife Mary Douglas
6 (c) If alive, give age 70(?) years

7. Birth date of deceased (mo., day, yr.) 6 - 22 - 04

8. AGE: Years	Months	Days	If less than one day
42	2	18	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Douglas
13. Birthplace South Carolina

MOTHER
14. Maiden Name Kate McDonald
15. Birthplace South Carolina

16 (a) Informant Mrs Mary Douglas
(b) Address 1710 Madison Ave

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-15-46 (month) (day) (year)
(c) Cemetery or crematory Blythewood S.C.
Location Blythewood S.C.

18 (a) Funeral director Mrs Leo F. Holland
(b) Address 1631 Druid Hill Ave

19 (a) SEP 17 1946 (b) (Date filed by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Sept. 1946, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Sept. 1946 to 10 Sept. 1946 and that I last saw him alive on 10 Sept 1946.

Immediate cause of death Coronary Failure — Duration

Due to Acute Congestive Failure

Due to Hypertensive Cardio-Vascular Dis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Abbott M. D.
Address Mercy Hosp. Date signed 10-10-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 170C

Registered No. G43636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Eastern Ave. Essex
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas Freet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1st 1902

8. AGE: Years	Months	Days	If less than one day
43 44	9	7	hr. min.

9. Birthplace Shippensburg Penna (Town, county and state)

10. Usual Occupation Transportation

11. Industry or business American Smelting

FATHER
12. Name Samuel Frut
13. Birthplace Shippensburg Penna

MOTHER
14. Maiden Name Myra Hazelbringer
15. Birthplace Shippensburg Penna

16 (a) Informant Mr Jackson L. Smith
(b) Address 123 Eastern Ave Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12th 1946 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director Leo G. Leach
(b) Address 1744 N Patterson Park ave

19 (a) SEP 11 1946 (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 19 , at 2.30 P. M

21. I certify that I took charge of the remains described above, held an autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Broken Back
Ruptured Spleen
Due to Internal Injuries Thoracic
Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-46 at Balto. Co. 2 A. M.
(b) Where did injury occur? Eastern Ave. &Terrace Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pediastrian-struck by auto
23. Signature Thos J. Mason M.D.
Medical Examiner.
Date signed 9-9-46

VS 181

G43637. BALTIMORE CITY HEALTH DEPARTMENT ✓164c Registered No. G43637

CERTIFICATE OF DEATH

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 McKean Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 McKean Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Kellie) Kelley Britt

3 (b) If veteran, name war: World War # 2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Britt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace: Newsoms, Virginia. (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business: Baltimore Transit Co.

FATHER
12. Name: Joseph T. Britt
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Sallie B. Barnes
15. Birthplace: Virginia

16 (a) Informant: [illegible] Britt
(b) Address: 534 Center Ave, Ports, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Anne Arundel Co, Md.

18 (a) Funeral director: William A. Jackson
(b) Address: 916 Penna. Ave.

19 (a) (Date rec'd by registrar) (b) [illegible]

VS 19 SEP 11 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1946, at 3.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of Heart

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-46 at 3 P. M.
(b) Where did injury occur? 818 Mc Kean Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury: Firearms

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 9-9-46

X

343638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 643638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818- McKean Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 McKean Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Arrington Britt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	MARRIED

6 (b) Name of husband or wife Kelley Britt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 15, 1915

8. AGE: Years	Months	Days	If less than one day
31	7	23	hr. min.

9. Birthplace Rapp, Virginia.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Harry Jackson
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Jones
15. Birthplace Virginia

16 (a) Informant William W. Jackson
(b) Address 2015 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co, Md,.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna., Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 81 SEP 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1946 at 3.30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of chest involving lung & heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-46 at 3 P. M.
(b) Where did injury occur? 818 McKean Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gun shot wounds

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 9-9-46

G43639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Reg. G43639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W COLDSPRING LANE
(c) Hospital or institution: CONVALESCENT HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 MO
(e) Length of stay in Baltimore (yrs., mos., or days) 1901

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 W. FAYETTE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W HARDING

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months 9 | Days — | If less than one day: hr. min.

9. Birthplace FREDERICK MD
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name MARSHALL F. HARDING
13. Birthplace FREDERICK MD

MOTHER
14. Maiden Name CLARA C SMITH
15. Birthplace FREDERICK MD

16 (a) Informant MAUD M. FINK
(b) Address 46 E WEST ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 12/46 (month) (day) (year)
(c) Cemetery or crematory MOUNT OLIVET
Location FREDERICK MD

18 (a) Funeral director AMBROSE INC
(b) Address 414 N FRANKLINTOWN RD (Washington Funeral Home)

19 (a) SEP 1 1946 (Date received by Registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1946, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946 to Sept. 9 1946, and that I last saw him alive on Sept 9 1946.

Immediate cause of death	Duration
LOBAR PNEUMONIA.	1 Day.
Due to MYOCARDIAL INSUFFICIENCY.	5 days.
Due to CORONARY THROMBOSIS.	10 days.
Other Conditions FRACTURED- Rt. Hip.	2 months.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/5
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 6-15-46 at A. M.
(c) Where did injury occur? 2101 W. Coldspring Ln. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? Convalescent home While at work? No
(Specify type of place)
(e) Means of injury slipped + fell to floor

23. Signature Thomas R. Hannan M. D.
Address 3803 Edmondson Ave Date signed 9/14/46

For P.C. Lutowski, by Howard J. Mendelsohn, M.D.

Form approved. Budget Bureau No. 42-R713.4. 16-50000-2

Instructions: Items must be answered or explained. If unknown or inapplicable, write none. Answers to items 12-15 and 20-22 are required in all cases. Items 16-19 are required when applicable. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G43640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 120 B

G43640
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Today
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Hooper Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Gannon.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-24-9399

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1928

8. AGE: Years 18 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Student.

11. Industry or business

FATHER
12. Name Lloyd H. Gannon
13. Birthplace Maryland.

MOTHER
14. Maiden Name Beulah E. Becker.
15. Birthplace Maryland.

16 (a) Informant Beulah E. Brooks.
(b) Address 3610 Hooper Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Ehrenwerth Bros
(b) Address 3615-17 Chestnut Ave

19 (a) (Date received by registrar) SEP 13 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8, 1946, at 7.45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1946 to Sept 8 1946, and that I last saw h- alive on Sept 8 1946

Immediate cause of death: Cardiorespiratory Failure — Duration

Due to: Acute Fulminating Ulcerative Colitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Aug 24 1946

Major findings of operation: Inflamed Colon

of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Resach
Address Univ. of Md. Hospital Date signed 9/8/46 (M. D.)

Redwood & Greene Sts. X

G43641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

G43641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dakeland St
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (~~months~~ or days): 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 W. north ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hann.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-3111

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Lena J. Hann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1900

8. AGE: Years	Months	Days	If less than one day
46	3	8	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Carpenter.
11. Industry or business

FATHER
12. Name Samuel J. Hann
13. Birthplace Maryland

MOTHER
14. Maiden Name Sadie Myers.
15. Birthplace Maryland.

16 (a) Informant Mrs. Allen Hann.
(b) Address 1315 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/46 (month) (day) (year)
(c) Cemetery or crematory Manchester, Md.
Location Maryland

18 (a) Funeral director Jacobs & Jenkins Sons.
(b) Address Manchester, Md.

19 (a) (Date rec'd by registrar) SEP 11 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1946 at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1946 to Sept 9 1946, and that I last saw h[illegible] alive on Sept 4 1946

	Duration
Immediate cause of death Cardiac failure	8 mons.
Aortic insufficiency	
Due to Chr. necr. aortitis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lemard E. Blumenthal M. D.
Address W B & H Date signed 9/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G43642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 Ramsey St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Ramsey St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Anna Fuller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William H. Fuller
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1890

8. AGE: Years 56 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business —

FATHER
12. Name George Fick
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Margaret Oppelt
15. Birthplace Baltimore, Md.

16 (a) Informant Husband Wm H. Fuller
(b) Address 2000 Ramsey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 Sept 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director A. B. Shippert & Son
(b) Address 1300 Eutaw Place

19 (a) — (Date rec'd by registrar) (b) — Registrar

VS Form SEP 11 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep 9 1946, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 9 1946 to Sep 9 1946 and that I last saw her alive on Sep 9 1946.

Immediate cause of death: Coronary Thrombosis — Duration 4 Hours

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 Wilkens Ave Date signed Sep 9, 1946

X

G43643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G43643

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 Monument St
(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Mc Allen Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMIE STARK

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-03-0950

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Henry
13. Birthplace Alabama

MOTHER 14. Maiden Name Sadie
15. Birthplace Alabama

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Frederick + Hamilton Aves

18 (a) Funeral director Clark Lewis Inc
(b) Address 1439 E. Balto St

19 (a) 13 1946 (Date received by registrar) (b) Registrar's Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dead on Arrival 19 to 19
and that I last saw h alive on 19
Immediate cause of death Myocardial failure

	Duration
Due to Coronary Occlusion	
Due to Coronary Thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Coronary thrombosis Acute myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged gratis-follow

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Rosten M. D.
Address Sinai Hosp Date signed 9/11/46

VS 150

Every item of information known is carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43644 Preston

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G43644 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 East Madison St
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 East Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston B. Lipscomb

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-9981

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Rose Lipscomb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1897

8. AGE: Years	Months	Days	If less than one day
48	8	15 16	hr. min.

9. Birthplace Henrico County Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name London Lipscomb
13. Birthplace Henrico County Va

MOTHER
14. Maiden Name Helen Cephers
15. Birthplace Henrico County Va

16 (a) Informant Mrs Helen Lipscomb
(b) Address 1630 East Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Centre Mem Park
Location Baltimore County Md

18 (a) Funeral director Joseph A. Lively
(b) Address 66 West Pagne St

19 (a) 9-11-1946 (Date received by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1946, at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 46 to Sept 9 19 46, and that I last saw him alive on Sept 9 19 46.

Immediate cause of death: Aneurysm Aorta — Duration 6 mos

Due to: Hypertension

Due to:

Other Conditions: Nephritis Chr.

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young M.D.
Address 1424 E Monument Date signed 9/11/46

VS 150

X

PRINT: Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G43645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G43645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Ruley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Clara E. Berger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1871

8. AGE: Years	Months	Days	If less than one day
74	8	17	hr. min.

9. Birthplace Wilmington Del.
(Town, county, and state)
10. Usual Occupation Chief Elec.
11. Industry or business Standard F. Co. Curtis

FATHER
12. Name Samuel
13. Birthplace Wilmington Del

MOTHER
14. Maiden Name Gertrude B. Merkel
15. Birthplace Havre-De-Grace Md

16 (a) Informant Wife
(b) Address 1704 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) SEP 11 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/ 1946, at 8.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16/ 1945 to 9/8/ 1946 and that I last saw h.i. alive on 9/8/ 1946.

Immediate cause of death	Duration
Spontaneous pneumothorax	about 10 mths
Due to Tb. pulmon.	
Due to	
Other Conditions Spondylarthritis deformans	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Weinberger M.D.
Address 912 Brookfarm Date signed 9/10/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43646 BCH G39889 G43646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓1190

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 S.Bouldin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 S.Bouldin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Leikam ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.12,1946

8. AGE: Years	Months	Days	If less than one day
	7	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George H.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Minnie K.Winslow
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address 1010 S.Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.12/46 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

19 (a) ~~SEP 11 1946~~ Huntington Williams, M.D. (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946, at 7 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Sept 9 1946 and that I last saw him alive on Sept 9 1946.

Immediate cause of death
Acute Tuberculosis
Bronchopneumonia

Duration
9-2-46
9-2-46

Due to

Due to

Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Tuberculosis
Address 842 S Eaton Ave Date signed 9-10-46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43647 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114- Hull Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114- Hull Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Perry

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-1586

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13th 1874

8. AGE: Years	Months	Days	If less than one day
72	4	27	16 hr. min.

9. Birthplace Canada
(Town, county, and state)
10. Usual Occupation Retired Stevedore
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Evelyn Appleton
(b) Address 1114 Hull St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Annapolis Blvd.

18 (a) Funeral director Chas. T. Dill.
(b) Address 1521 E Fort Ave.

19 (a) (b) Huntington Williams, M.D.
(Registrar's signature)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946, at 10.30 A. M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular
Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 9/9/46

X

G43648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G43648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 S. Eutaw Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 S. Eutaw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary White

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed —

6 (b) Name of husband or wife Clearnie White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Morgan Munn —
13. Birthplace Kent Island Md.

MOTHER 14. Maiden Name Phelps Heath
15. Birthplace Kent Island, Maryland.

16 (a) Informant Felix M. Munn —
(b) Address 721/2 W. Mulberry St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9 VS 46
(month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cemtery
Location Balto.

18 (a) Funeral director Walter D. Long
(b) Address 134 W. Lanvale St

19 (a) (b)
Date received by registrar SEP 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1946 at 6:A M

21. I certify that death occurred on the date above stated, that attended decedent from Aug. 25 1946 to Sept. 7 1946, and that I last saw h alive on Sept. 8 1946

Immediate cause of death

	Duration
Coronary Thrombosis	8 days
Due to Influenza	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Colby Skeldon M. D.
Address 2088 E. Chase St Date signed 9-9-1946

X

A PERSON WILLFULLY MAKING A FALSE STATEMENT OR SUPPRESSING ANY MATERIAL FACT IN THIS CERTIFICATE, MAY BE GUILTY OF A MISDEMEANOR AND UPON CONVICTION THEREOF SHALL BE PUNISHED BY A FINE OF NOT MORE THAN $500 OR BY IMPRISONMENT FOR NOT MORE THAN ONE YEAR, OR BOTH. Sec. 1, Art. 43, Annotated Code of Maryland, 1939 Edition.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

Registered No. G43649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1052- W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1052- W. Fayette Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mamie Davis Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-1902

8. AGE: Years 43 Months 11 Days 24 If less than one day hr. min.

9. Birthplace Fayetteville, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Thomas

13. Birthplace Fayetteville, N.C.

MOTHER 14. Maiden Name Lizzie Ray

15. Birthplace Fayetteville N C.

16 (a) Informant Mamie D. Thomas

(b) Address 1052 W. Fayette St

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Sept. 13, 1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 N. Schroeder St

19 (a) 9 11 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946, at 11.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis and Syphilitic heart disease

Due to Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 9-9-46

VS 151

G43650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Diamond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Queenstown, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Anthony Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hall
15. Birthplace Md

16 (a) Informant Robert Wilson (Friend)
(b) Address 315 Diamond St
17 (a) Burial (b) Date thereof Sept 12, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St
19 (a) SEP 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/46 19 at 8:00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner
Date signed 9/9/46

X

G43651

BALTIMORE CITY HEALTH DEPARTMENT

No. 26750 CERTIFICATE OF DEATH 1937 Registered No. G43651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 2-10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1053 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minerva Cottman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. ? ? ?

8. AGE: Years	Months	Days	If less than one day
? 52	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Reed
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem.
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St.

19 (a) [illegible] Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH Sept 8/1946 19 at 11.07 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28/ 19 46 to Sept 8 19 46 and that I last saw h er alive on Sept 8/46 19

Immediate cause of death Cerebro-vascular accident — Duration

Due to Arteriosclerotic C-V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto City Hosp Date signed 9-8-46

X

G43652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47

G43652 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days 6
(e) Length of stay in Baltimore (yrs., mos., or days) 71 years 5

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Savage

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-75

8. AGE: Years	Months	Days	If less than one day
71	4	7	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Savage
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Ashley
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 12 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn Md

18 (a) Funeral director Geo. O. Wilson
(b) Address 1210 Brantley ave

19 SEP 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1946, at 7 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1946, to Sept 8 1946, and that I last saw him alive on Sept 8 1946.

Immediate cause of death Renal Failure + uremia, chronic — Duration

Due to Arteriosclerosis, generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bruce D. Franz
Address The Johns Hopkins Hospital Signed M.D.

VS 150

X

Please write information asked for carefully and legibly. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

G23653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

Registered No. G23653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 31

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) 10 D

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Mansby St Rear (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL OLSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 10 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26/46 19 , at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Davis M.D.
Medical Examiner.
Date signed 8/27/46

C43654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C 43654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 West Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARVEY CAMERON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Laborer

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 1 01946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 1 1946 (Registered by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/46 19 at 8:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Prostatic Hypertrophy

Due to

Other Conditions
Hypertensive Cardiovascular Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Gaers M.D.
Medical Examiner.
Date signed 8/25/46

G23655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √166

G23655

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 - W. Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lloyd Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 10 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 11 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1946 at 2.50 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gunshot wounds of chest + back involving the heart + lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/7/46 at 2.40 P. M.
(b) Where did injury occur? Outside Berry + Fremont Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm - Murder

23. Signature Howard J. Mahoney M.D. Medical Examiner.
Date signed 8/8/46

VS 191

X

G43656 — BALTIMORE CITY HEALTH DEPARTMENT — G43656

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 E 23rd St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Vandelia Westcott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Negro

6 (a) Single, married, widowed, or divorced widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation House wife.

11. Industry or business None - H. wife.

FATHER
12. Name John Henry Thompson
13. Birthplace

MOTHER
14. Maiden Name Emma James Brown
15. Birthplace

16 (a) Informant Mrs. Emma Ball
(b) Address 434 E. 23rd St.

17 (a) C (Burial, cremation, or removal) (b) Date thereof 9-13-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date received by registrar SEP 11 1946 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION:

20. DATE OF DEATH 9-10 1946 at 6:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1946 to 9-10-1946 and that I last saw h alive on 9-9 1946.

Immediate cause of death Pulmonary Embolism.

Due to Multiple Myeloma.

Due to

Other Conditions Senility.

(Include pregnancy within 3 months of death)

Date of operation 9-4-46.

Major findings of operation: Ulcer & whitish & necrotic bone of left lower leg

of autopsy: None.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. R. L. Jackson. / Dr. Robinson.
Address Provident Hosp. Date signed 9/14/46 M.D.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1/61

G43657 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamptnett Ave
(c) Hospital or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Chestnut Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Ditto

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife D. Oliver Ditto
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 3. 1874

8. AGE: Years	Months	Days	If less than one day
72	1	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER 12. Name Henry Seymour
13. Birthplace Md

MOTHER 14. Maiden Name Dorothy Ballard
15. Birthplace Md

16 (a) Informant Maurice D. Ditto
(b) Address 511 Tunbridge Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13-1946 (Month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian Cemetery Location

18 (a) Funeral director Chas. Sumwalt Sons
(b) Address 801 W. Fayette St

19 (a) (Date received by registrar) Huntington Williams M.D.

11 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10. 1946 at 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946 to Sept 10 1946 and that I last saw h. C. alive on Sept 9 1946

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Diabetes Mellitus	
Due to Arteriosclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 360 Shannon Drive Date signed Sept. 11-46

X

Correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G43658 BALTIMORE CITY HEALTH DEPARTMENT G43658
CERTIFICATE OF DEATH 51B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 E. 26TH ST.
(c) Hospital or institution: qrf
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 E. 26TH ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTIN . LARDNER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife MARGARET LARDNER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69 68			hr. min.

9. Birthplace IRELAND. (Town, county, and state)
10. Usual Occupation CITY EMPLOYEE.
11. Industry or business

FATHER
12. Name MICHEAL LARDNER
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY DUNN
15. Birthplace IRELAND

16 (a) Informant MARY MRS LARDNER
(b) Address 500 E. 26TH ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL.
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND ST.

19 (a) Date received by registrar (b) Registrar

SEP 1 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9TH 1946 at 6. 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1942 to Sept. 1946 and that I last saw him alive on Sept. 1 1946.

Immediate cause of death Carcinoma of Prostate — Duration 3 yrs.

Due to

Due to

Other Conditions Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammerer Jr. M.D.
Address 3015 Sheridan Ave Date signed 10 Sept 46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43659

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4407 Harcourt Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Harcourt Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Giacchelli

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Peter Giacchelli
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Antonio Bove
13. Birthplace: Italy

MOTHER
14. Maiden Name: Filomena Votta
15. Birthplace: Italy

16 (a) Informant: R. Medaglia
(b) Address: 4407 Harcourt Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/46 (month) (day) (year)

(c) Cemetery or crematory: Altoona
Location: Altoona Pa

18 (a) Funeral director: Wm. Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) 9-11-1946 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1946, at 10 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Sept 11 1946 and that I last saw her alive on Sept 10 1946

Immediate cause of death: acute Coronary Occlusion — Duration: 1 day
Due to: Arteriosclerotic Heart Disease — 5 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: George Sawyer
Address: 4808 Harford Rd. Date signed: 9/12/46

VS 150

G43660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

Registered No. G43660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Melbourne (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Chase, George Collins

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jennie Tifft Chase
6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1869

8. AGE: Years: 76 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Uxbridge, Mass. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: William Chase
13. Birthplace: Mass.

MOTHER
14. Maiden Name: Ruth Bates
15. Birthplace: R.I.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-46 (month) (day) (year)
(c) Cemetery or crematory Location: Seymour, Conn.

18 (a) Funeral director: Oder Funeral Home
(b) Address: 404 York Road, Hunt

19 (a) SEP 12 1946 (Local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1946 at 5:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1946 to Sept. 11 1946 and that I last saw him alive on Sept. 11 1946

Immediate cause of death: Adenocarcinoma of ascending colon, perforated, causing generalized peritonitis. — Duration: UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/2/46

Major findings of operation: Adenocarcinoma mucous of ileum and colon, with obstruction

Of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 9/11/46

G43661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-937

Registered No. G43661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 W. Hamilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Anneslie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Overbrook Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY WEBER GLASER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	216-09-3677	Male	White	Married

6 (b) Name of husband or wife Edith May Glaser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1887

8. AGE: Years	Months	Days	If less than one day
58	9	1	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Consulting Engineer
11. Industry or business Henry Adams

FATHER
12. Name Adolf Glaser
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Schultze
15. Birthplace Balto.

16 (a) Informant Mr. Donald Glaser
(b) Address 608 Overbrook Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 12 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1946, at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1946, to 9/10 1946, and that I last saw h- alive on 9/10 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: acute

Due to Arteriosclerotic cardio-vascular disease — 1 yr +

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Edward Leuck, M.D.
Address 14 E. Eager St. Date signed 9/11/46

VS 150

Please write the causes of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G43662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G43662

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Madison Sts.
(c) Hospital or institution: Maryland General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Nonc
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phoebe C. Leicht

3 (b) If veteran, name war	3 (c) Social Security Account No.
Female	216-05-2749

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1874

8. AGE: Years	Months	Days	If less than one day
72	6	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None)
11. Industry or business

FATHER
12. Name John J. Leicht
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Frey
15. Birthplace Balto.

16 (a) Informant Mrs. Harry Hodges
(b) Address 609 Winans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) SEP 12 1946 (b) Signature of local registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1946, at 1 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 28 1946, to Sept 11 1946, and that I last saw h.. alive on Sept 11 1946.

Immediate cause of death Uremia, Duration
according to chronic nephritis

Due to

Due to

Other Conditions Arteriosclerosis, general

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. T. Davis M. D
Address Md General Hospital Date signed 9/11/46

VS 150

G43663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43663 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Road
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore Elsef.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Hochberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 50 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry

13. Birthplace Russia

MOTHER 14. Maiden Name Leba

15. Birthplace Russia

16 (a) Informant Joseph Hochberg

(b) Address 446 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1398 E. Balto St

19 (a) SEP 12 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Sept 12 1946 and that I last saw h[er] alive on Sept 11 1946.

Immediate cause of death: Exhaustion — Duration: 1 Week

Due to Obstruction of Bowel

Due to Carcinoma - Small Intestines

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1945

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Stanton J. Peale

Address 5076 Park Heights Ave Date signed Sept 24 1946

G43664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52 B

Registered No. G43664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution Hebrew Home for Aged 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Hemping & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME YETTA ZAMANSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Chana
15. Birthplace Russia

16 (a) Informant Rueben Zamansky
(b) Address 25 N. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Germon Hill Rd

18 (a) Funeral director Jacob Levy Inc
(b) Address 1439 E. Balto St

19 SEP 12 1946 (Date received by local registrar) Huntington Williams, M.D. Address Lexington Bldg

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 19 46 at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 19 44 to 9-12 19 46 and that I last saw h[illegible] alive on 9-12 19 46

Immediate cause of death Carcinoma of bladder — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Lexington Bldg Date signed 9-12-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

G43665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G43665 Registered No.

please write the causes of death clearly and legibly. Physicians: please fill in all items, if known. Any false statement is punishable by law. Typist: Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 S. Potomac St
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 S. Potomac St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME William H. Clark.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	married

6 (b) Name of husband or wife Christina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/1879

8. AGE: Years	Months	Days	If less than one day
67	5	24	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Christina Clark
(b) Address 910 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St

18 (a) Funeral director Tully & Zeth Inc
(b) Address 407 S. Wolfe St

SEP 12 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/ 1946 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28, 1945 to Sept. 10 1946, and that I last saw him alive on Sept. 10, 1946.

Immediate cause of death	Duration
Hepatic cirrhosis (Laennec)	1½ yrs
Due to Pulmonary edema	2 days
Due to Paroxysmal tachycardia	1 year
Other Conditions Myocardial insufficiency	2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Dr. Benedict Brennan Jr. M. D.
Address 3037 O'Donnell St Date signed 10-12-46

VS 150

G43666 FRohNAPFel G43666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 N. Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 88y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Frohnapfel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	widowed

6 (b) Name of husband or wife Gotha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/1856

8. AGE: Years	Months	Days	If less than one day
90	1	9	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Catherine Pfeiffer
(b) Address 521 N. Milton Ave

17 (a) Burial (b) Date thereof 9/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Selby & Zeile
(b) Address 413 S. Paca St

19 (a) SEP 12 1946 (b) Registrar Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/1946, at 4:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2nd 1945 to Aug 9th 1946, and that I last saw her alive on Aug 8 1946.

Immediate cause of death

	Duration
Cardio Vascular Collapse	2
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Tamkin M. D.
Address 100 N. Eutaw Date signed 9/13/46

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 150

G43667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G43667

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33rd STS
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE-2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1163 E. LOMBARD ST (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country ITALY

3 (a) FULL NAME FRANCESCO PICCIONE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MRS. FRANCESCO PICCIONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 6, 1885

8. AGE: Years 61. Months 2 Days 4 If less than one day hr. min.

9. Birthplace ITALY (Town, county, and state)

10. Usual Occupation GROCER

11. Industry or business GROCERY STORE

FATHER
12. Name BIAGGIO PICCIONE (D)
13. Birthplace ITALY

MOTHER
14. Maiden Name PAULINE PASTORE
15. Birthplace ITALY

16 (a) Informant BIAGGIO PICCIONE
(b) Address 1163 E. LOMBARD ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof September 12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 58 E. Morley St.

SEP 12 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 10, 1946, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 3 1946 to SEPT 10 1946, and that I last saw him alive on SEPT 10 1946

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration 8 days

Due to: HYPERTENSIVE CARDIO-VASCULAR DISEASE — Duration ?

Due to: —

Other Conditions DIABETES MELLITUS — Duration ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kulpfenhut, Jr. M.D.
Address Union Memorial Hosp. Date signed Sept 10-46

VS 180

93D

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G43668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Josephs 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County –
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 Holden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine N. Baummer BAUMMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (Married), widowed, or divorced.
F	W	

6 (b) Name of husband or wife Anthony J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-91

8. AGE: Years	Months	Days	If less than one day
54	10	15	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name George Grauer
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Sundergelt
15. Birthplace Md.

16 (a) Informant Mr. Anthony J. Baummer
(b) Address 5003 Holden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) SEP 12 1946 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1946 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1946 to Sept 12 1946 and that I last saw h[illegible] alive on Sept 12 1946.

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Chronic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evelyn Summerlin
Address Upper Marlboro Date signed 9/13/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G43669

Please write the causes of death clearly and legibly. Physicians: please write plainly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4705 Hampnett St.
(c) Hospital or institution:
Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Conduit St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Holliday, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah A. Holliday
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1863

8. AGE: Years	Months	Days	If less than one day
82	10	1	hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)
10. Usual Occupation Retired - Police
11. Industry or business Annapolis Police Dept

FATHER
12. Name John D. Holliday
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Annapolis, Md.

16 (a) Informant Mr. John D. Holliday, Jr.
(b) Address 7 Thompson St., Annapolis, Md.

17 (a) Burial (b) Date thereof Sept. 14, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Ann's Cemetery
Location Annapolis, Md.
18 (a) Funeral director E. W. Cameron
(b) Address 1005 W. Baltimore St.
19 (Date rec'd by registrar) SEP 12 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1946 at 4.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1946 to Sept 12 '46 and that I last saw him alive on Sept 12 '46

Immediate cause of death Coma
Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mrs. Holliday
Address 5103 Harford Rd. Date signed Sept 12 '46 M. D.

G43670 Rochner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G43670

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie H. Rochner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm. D. Rochner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1884

8. AGE: Years 62 Months 1 Days 27 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Helmrich

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Markson

15. Birthplace Germany

16 (a) Informant Wm D Rochner

(b) Address 2605 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto Md

18 (a) Funeral director Geo. L. Berger Jr

(b) Address 5611 Holchin St

19 (a) SEP 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9th 1946, at 11.45 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31st 1946 to Sept 9 1946 and that I last saw h.lt alive on Sept 9th 1946.

Immediate cause of death

Myocarditis — Duration 16 Days

Due to Cerebral Hemorrhage (Left sided hemiplegia) — 2 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Hale

Address 517 Aisquith St Date signed 9/12/46 M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G43671

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (years, months, or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Paine Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Benjamin Meeker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1900

8. AGE: Years	Months	Days	If less than one day
46	7	-	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business Taxicab (Sun)

FATHER
12. Name William Meeker
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Annie Slater
15. Birthplace Baltimore, Md

16 (a) Informant Lawrence Meeker
(b) Address 1017 W. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Bolton Hill.
Location Baltimore Md

18 (a) Funeral director Geo. Y. Berger Jr
(b) Address 1562 Hollins St

19 (a) Filed Sep 13 1946 (b) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 September 1946, at 7 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Aug 1946 to 11 Sept 1946, and that I last saw him alive on 11 Sept 1946

Immediate cause of death: Coronary Occlusion — Duration: 19 days

Due to

Due to

Other Conditions: Peptic Ulcer
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Memorial Hosp. Date signed

SEP 13 1946

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43672 Wiff

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 161 C

G43672 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 9 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Walbrook St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Witt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1946

8. AGE: Years | Months: 9 (in hours) | Days: — | If less than one day: 3½ hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Daniel Witt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dorothy Wojtowski
15. Birthplace Mount Carmel, Pa.

16 (a) Informant —
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem. Location Baltimore

18 (a) Funeral director Fred O. Zurlle
(b) Address 1930 Eastern Ave.

19 SEP 12 1946 Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1946 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1946 to Sept 11 1946, and that I last saw him alive on Sept 11 1946.

I state cause [illegible] Atelectasis Pulmonary Edema

Due to Unknown

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation?

of autopsy? Pulmonary Edema

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2307 Eastern Ave. Date signed 9/12/46

G43673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12215

G43673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount.
(c) Hospital or institution: The Church Home and Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME Hensel, Charles Albert.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs. Margaret R. Hensel.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 27 Jan. 1864

8. AGE: Years	Months	Days	If less than one day
82	7	19	hr. min.

9. Birthplace Philadelphia PA.
(Town, county, and state)
10. Usual Occupation Clergyman.
11. Industry or business

BROTHER / FATHER
12. Name William Hensel
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary E Hary
15. Birthplace Pennsylvania.

16 (a) Informant Patient
(b) Address see above.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemy.
Location Woodlawn Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1800 Eutaw Place

19 SEP 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Sept 1946, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Sept 1946 to 10 Sept 1946 and that I last saw h[im] alive on 10 Sept 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Peritonitis	
Due to Volvulus & gangrene sigmoid colon.	
Other Conditions Old age.	

(Include pregnancy within 3 months of death)
Date of operation 10 Sept 1946
Major findings of operation: Volvulus of sigmoid colon & necrosis.
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas J. Kohlerman M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 100

G43674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St + Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 W. Mulberry St (If rural, give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country China.

3 (a) FULL NAME LOW, King
3 (b) If veteran, name war No
3 (c) Social Security Account No. None
4. Sex Male
5. Color or race Chinese
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) — 1884
8. AGE: Years 62 Months — Days — If less than one day hr. — min.
9. Birthplace China (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Restaurant.
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden Name Unknown
15. Birthplace
16 (a) Informant Mr. John Moran
(b) Address 217 W. Mulberry St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn
18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (R. F. BUGGE SUC.) 108 N. HOWARD AVENUE
(c) Date received SEP 12 1946 (d) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Sept 1946, at 12:00 M
21. I certify that death occurred on the date above stated; that I attended deceased from 10 Sept 1946 to 11 Sept 1946 and that I last saw h. alive on 11 Sept 1946.
Immediate cause of death Pulmonary Edema — Duration 2 days
Due to
Due to
Other Conditions Hypertension CVD
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature]
Address Union Mem Hosp Date signed Sept 13 1946 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G43675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G43675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Sheldon St
(c) Hospital or institution Mrs. H. A. Skinner Hurley Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Guilford (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Ellen Kerr

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: J. Wesley Kerr
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27 1869

8. AGE: Years 77 Months 3 Days 14 If less than one day hr. min.

9. Birthplace Bells. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Samuel L Burgess
13. Birthplace Bells. Md

MOTHER
14. Maiden Name Mary A. O'Laughlin
15. Birthplace Bells. Md.

16 (a) Informant Mr. Wallis B. Kerr - Son
(b) Address Stonewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-46 (month) (day) (year)
(c) Cemetery or crematory Green Mt.
Location Baltimore Md

18 (a) Funeral director STEWART & MOWEN COMPANY (R. F. Mowen Sub.) 108 W. North Avenue
(b) Address
(c) Date received 9 12 1946 (Signature of Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1946 at 9 P M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1 1946 to Sept 10 1946 and that I last saw him alive on Sept 9 1946.

Immediate cause of death

Duration

Due to Dysphagia Paralytica 1 Yr
Due to Cerebral Arteriosclerosis 1 Yr
Other Conditions 7 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Kerr M. D.
Address 1 W Mt Royal Ave Date signed 9-11-46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G43676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G43676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Arlington Pk. Apts.
(b) Street address Pk. Heights & Clarks Lane.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Arlington Park Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MORTON HAMBURGER.

3 (b) If veteran, name war:
3 (c) Social Security Account No. 212-07-8511.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen B. Hamburger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1882

8. AGE: Years	Months	Days	If less than one day
64	5	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Lewis Hamburger,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rosa Hamburger,
15. Birthplace Germany.

16 (a) Informant Mr. A. Hamburger,
(b) Address Arlington Park Apts.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/13/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Baird Somerville & Long
(b) Address 1902 Eutaw Place.

19 (a) SEP 12 1946 (Date rec'd by registrar) (b) Washington Wilkinson

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11th. 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22° 1941 to Sept 11° 1946 and that I last saw h.im alive on Sept 11° 1946.

Immediate cause of death: Cerebral Hemorrhage (Second)

	Duration
Due to Arteriosclerosis of Cerebral arteries	Aug 23 1946
Due to Generalized arteriosclerosis	
Other Conditions Recurrent L. femi plegia due to Cerebral Hem. (Include pregnancy within 3 months of death)	Aug 22° 41

Date of operation
Major findings of operation:
of autopsy: Evidences confirming the above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 150

G43677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G43677

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) About 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Walbrook Ave. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) FULL NAME JULIUS S. FALK.

3 (b) If veteran, name war:
3 (c) Social Security Account No. 217-01-4942.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Rose Falk
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 29, 1872.
8. AGE: Years 73 Months 11 Days 13 If less than one day hr. min.
9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Retired Bookkeeper.
11. Industry or business

FATHER
12. Name Simon Falk,
13. Birthplace Germany.

MOTHER
14. Maiden Name Clara Schwarz,
15. Birthplace Germany.

16 (a) Informant Mrs. Fannie Krahling,
(b) Address 3806 Fourth St. Brooklyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebraw
Location Balto. Md.

18 (a) Funeral director Harris Levine Sons
(b) Address 1902 Eutaw Place.

19 (a) SEP 12 1946 (Date rec'd by Registrar) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1946 at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946 to Sept 11 1946 and that I last saw h[im] alive on Sept 11 1946

Immediate cause of death	Duration
Pulmonary Edema	
Due to	
Due to	
Other Conditions Peritonitis Diverticulosis	

(Include pregnancy within 3 months of death)

Date of operation 8-14-46
Major findings of operation: Perforation of sigmoid.
of autopsy: Pulmonary Edema, Peritonitis, Diverticulosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Paulsen, M.D.
Address Sinai Hospital Date signed 9/14/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G43678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G43678

Registered No.

M. 104195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wise Ave Box. 66
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15/ 1875

8. AGE: Years 71 Months 1 Days 24 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Efforl
13. Birthplace ? Va.

MOTHER
14. Maiden Name ? Nennie
15. Birthplace ? Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. Ruth O. Elliott, Dundalk
(b) Address 1129 N. Caroline St.

19 (a) [illegible] (b) [illegible]

SEP 13 1946

SEP 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9/1946 19 , at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11/ 19 46 to Sept 9/46 19 ; and that I last saw h[illegible] alive on Sept 9/ 19 46.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions: Senility, heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Loy C. Wallace M. D.

Address B. C. H. Date signed 9/10/46

830a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43679
AB-104370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G43679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 12-9
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 E. 20th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 72?

8. AGE: Years 72? Months ? Days ? If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) 9/14/46 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Levy Hill Cem
Location Laurel Md

18 (a) Funeral director W. C. Hutt Co
(b) Address Laurel Md.

19 (a) (Date received by Registrar) (Registrar) Huntington Williams, M.D.

SEP 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1946 at 10.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1946 to 9-11 1946, and that I last saw her alive on 9-11- 1946

Immediate cause of death: Ruptured pneumonia — Duration: 1 week

Due to

Due to

Other Conditions Anemia & Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: G.S. 9/12/46

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Rowell Hoffmeister M. D.
Address Baltimore City Hosp Date signed 12 Sept 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G43680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga. 27-10.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3324 Reisterstown Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara T ~~Donahue~~ Don Dero

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Frank Don Dero
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 8-3-1868

8. AGE: Years 78 | Months 1 | Days 8 | If less than one day: hr. ____ min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business ——

FATHER
12. Name Michael Wallace
13. Birthplace Ireland.

MOTHER
14. Maiden Name Anna Docherty
15. Birthplace Ireland.

16 (a) Informant Mrs. Virginia Houle
(b) Address 3324 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Buck
(b) Address 2054 Harford Ave.

SEP 13 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1946, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-28 1946 to Sept-11 1946, and that I last saw her alive on Sept-11 1946.

Immediate cause of death: Resp. Failure — Duration

Due to Pulmonary Embolism

Due to Gangrene Lt. Leg

Other Conditions Generalized Arterio sclerosis.
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: ——

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Thomas B. Lebherz
Address Mercy Hosp. Date signed 9/11/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G43681
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St 27-6
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town ~~2602~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Gilbons (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife William J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-1-1880

8. AGE: Years	Months	Days	If less than one day
66	7	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Elling Lane
13. Birthplace Germany

MOTHER 14. Maiden Name Julia
15. Birthplace Germany

16 (a) Informant William J Schneider
(b) Address 2602 Gilbons Ave

17 (a) Burial (b) Date thereof 9-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Leonard J Rynde
(b) Address 5305 Harford Rd.

19 (a) (b) Huntington Williams, M.D.
(Signature of local registrar) Registrar

SEP 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1946 at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1946 to Sept 12 1946 and that I last saw h[illegible] alive on Sept 12 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Cardiac decompensation	
Due to Hypertensive vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Burke M.D.
Address 24 Jo Hop Date signed 9-12-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G43682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 Lutland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Lutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Cephas Allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1902

8. AGE: Years 44 | Months 3 | Days 1 | If less than one day hrs. min.

9. Birthplace Baltimore, Md. (City, county, and state)

10. Usual Occupation At-Home

11. Industry or business

MOTHER / FATHER

12. Name David Booze

13. Birthplace Unknown

14. Maiden Name Frances ?

15. Birthplace Unknown

16 (a) Informant Fielder D. Booze (Bro)

(b) Address 232 S. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Robert L. Young

(b) Address 1216 N. Caroline St.

19 (a) SEP 13 1946 Huntington Williams, M.E.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1946, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Sept 11 1946 and that I last saw h[illegible] alive on Sept 11 1946.

Immediate cause of death Broncho - Pneumonia — Duration 2 days

Due to

Due to

Other Conditions Chronic Nephritis Mitral Insufficiency, Hypertension — 15 mos

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ralph L. Young M. D.

Address 1424 E. Monument Date signed 9/12/46

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G43683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2562 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2562 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul G. Leroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Wilhelmina Leroy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1883

8. AGE: Years	Months	Days	If less than one day
63	6	18	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Salesman

FATHER
12. Name Frederick Zerewski
13. Birthplace Germany

MOTHER
14. Maiden Name Renata Zielke
15. Birthplace Germany

16 (a) Informant Mrs. Wilhelmina Leroy
(b) Address 2562 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.
18 (a) Funeral director Harry A. Whitsell
(b) Address 4101 Edmondson Ave.
19 (a) SEP 13 1946 (Registrar) (b) Huntington Hilligoss, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11/46. 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17-45 19 to 9-11-46 and that I last saw h alive on 9-11-46 19

Immediate cause of death Coronary Thrombosis — Duration 13 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry L. Hubbell, M. D.
Address 2703 Edmondson Ave. Date signed 9-14-46

Physicians: please write the causes of death clearly and legibly. ... correct age is especially important.

G43684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G43684
Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave. 28-4
(c) Hospital or institution:
General German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katharina von Kennen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1861.

8. AGE: Years	Months	Days	If less than one day
84	11	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michael Silbert
13. Birthplace Germany

MOTHER
14. Maiden Name Katharina Schneider
15. Birthplace Germany

16 (a) Informant Mr. J. George Walz
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13/46
(month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Harry A. Neitzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

SEP 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11/46. 19 11.55 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20/46 to Sept. 11/46. and that I last saw her alive on Sept. 10/46.

Immediate cause of death

	Duration
Diabetic Coma.	12 hrs.
Due to Diabetes Mellitis. Unknown.	
Due to Multiple Sclerosis. Unknown.	

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry Hoeltje Chandler M.D.
Address 933 Hanover St. Date Sept. 12/46.

X

G43685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43685 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write with indelible pencil. Be careful to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Gillis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida H. Gillis nee Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1881.

8. AGE: Years	Months	Days	If less than one day
64	10	17	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Iron Moulder
11. Industry or business U.S. Navy Yard

FATHER
12. Name Hilbert Gillis
13. Birthplace England

MOTHER
14. Maiden Name Jane Kampe
15. Birthplace England

16 (a) Informant Mrs. Ida H. Gillis
(b) Address 207 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14/46. (month) (day) (year)
(c) Cemetery or crematory Louden Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Burke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1946 at 4:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 15 1946 to Sept 11 1946 and that I last saw him alive on Sept 11 1946

Immediate cause of death: Myocardial infarct — Duration 26 days

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 331 Cathedral St. Date signed

VS 150

G43686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. G43686

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring Ave - Belvedere
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balti. (If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring Ave - Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HERMINA HERSHKOVITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 Months Days If less than one day hr. min.

9. Birthplace Hungary (City, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name —
13. Birthplace Hungary

MOTHER
14. Maiden Name —
15. Birthplace Hungary

16 (a) Informant Mrs. Frieda Arnold
(b) Address 2932 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-46 (month) (day) (year)
(c) Cemetery or crematory Nelson Memorial Park
Location

18 (a) Funeral director Joe Lewis Inc
(b) Address 1429 E. Balto St

19 (a) SEP 13 19 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1946 at 12 (AM) PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941 to 9-12 1946. and that I last saw h alive on 9-12 1946.

Immediate cause of death Cerebral Hemorrage — Duration

Due to Hypertension Arteriosclerosis

Due to

Other Conditions Hyperthyroidism Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 9-12-46

VS 150

x Nagel

G43687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G43687 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1326 Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 N. Lafayette ave.
(e) Citizen of foreign country? (If so, give nation) (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Warren Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-9793

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Georgia (city or town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER
12. Name Steve Daniels
13. Birthplace Georgia

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Georgia

16 (a) Informant Gladys Daniels
(b) Address 1326 Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/46 (month) (day) (year)
(c) Cemetery or crematory, Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b)
(Date received by Registrar) SEP 13 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11, 1946 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1946 to Sept 11 1946, and that I last saw h[illegible] alive on Sept 6 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George McDonald
Address 844 W Cary Date signed 9/11/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G43688 Registered No.

Please write the causes of death clearly and legibly. Physicians: please report correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. # 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Griffin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	B	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace
14. Maiden Name —
15. Birthplace

16 (a) Informant Maggie Griffin
(b) Address 941 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill, Md.

18 (a) Funeral director G. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 SEP 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1946 at 10 ~~AM~~ PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1946 to 9/7 1946, and that I last saw h[illegible] alive on 9/7 1946

Immediate cause of death Cardio respiratory failure — Duration

Due to Arteriosclerotic cardiovascular disease, cardiac hypertrophy & dilatation, cardiac failure grade IV, urinary retention & prostatism

Other Conditions Benign Prostatic Hypertrophy, possible postal arrhythmia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Univ. Hosp. Date signed 9/11/46

G43689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Madison Ave.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John [redacted] Leaner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace M. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Miss R. Friedmond
(b) Address 1128 Argyle Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery [redacted] Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Millburn Registrar

VS 150 SEP 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1946 to 9-11 1946 and that I last saw h[redacted] alive on 9-6-46 1946

Immediate cause of death: Pulmonary Cardiovascular Disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. Atwell Jones M. D.
Address 5 S Wolfe St Date signed 9-12-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 B

G43690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 Smith Ave
(c) Hospital or institution: 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Smith Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa V. Carr

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James J. Carr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18 1863

8. AGE: Years 82 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Salisbury Md (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Charles Guthrie
13. Birthplace Salisbury Md

MOTHER 14. Maiden Name Mark
15. Birthplace Salisbury Md

16 (a) Informant H. C. Becker
(b) Address 1912 Griffis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Fullmer & Lockard
(b) Address 1217 E. Fort Ave

19 (a) SEP 13 1946 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1946 at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1946 to Sept 7 1946 and that I last saw her alive on Sept 7 1946

Immediate cause of death: Cerebral thrombosis, left — Duration 11 days

Due to Arteriosclerosis interstitial nephritis Generalized — 10 yrs

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Uelsch Jr. M. D.
Address 1222 Wash Blvd Date signed Sept 12 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G43691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Iris Ave
(c) Hospital or institution:
264
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Iris Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles R. N. Safft

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Viola E. Safft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26th 1878

8. AGE: Years 68 | Months 2 | Days 15 | If less than one day — hr. — min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Penna. R.R.

FATHER 12. Name Charles A. Safft

FATHER 13. Birthplace Balto Md.

MOTHER 14. Maiden Name Ellen Parsons

MOTHER 15. Birthplace Baltimore Md

16 (a) Informant Mrs Hazel E Virsa

(b) Address 6115 Fairdale Ave

17 (a) Burial (Burial, cremation, entombment) (b) Date thereof 9/14/46 (month) (day) (year)

(c) Cemetery Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) 1946 Registrar

SEP

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11th 1946, at 11 30 M.

21. I certify that death occurred on the date above stated, that I attended deceased from Apr. 1943 to Sept. 11, 1946 and that I last saw him alive on Sept. 11, 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 yr.

Due to: Hypertensive Cardiovascular Disease — 5 yrs.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)

(e) Means of injury —

23. Signature Wm. McCannebaker

Address 2740 St. Paul St. Date signed 9/12/46.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G43692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-2
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 S Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Mangano

3 (b) If veteran, name war: N
3 (c) Social Security Account No. DEAD

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1882

8. AGE: Years	Months	Days	If less than one day
64	2	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Self
11. Industry or business Boat Rental

FATHER
12. Name Lazzaro Mangano
13. Birthplace Palermo Sicily

MOTHER
14. Maiden Name Mary McIntire
15. Birthplace Ireland

16 (a) Informant Michael S. Mangano
(b) Address 718 Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 19 46 at 11:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH - Coronary disease
Hypertrophy + dilatation of heart
Edema + congestion of lungs
Due to Advanced aortic atheroscleroses + Chronic
Other Conditions nephritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mancuso M.D.
Medical Examiner.
Date signed 9/11/46

G43693

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43693

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adlee L Bohannon

3 (b) If veteran, name war: N

3 (c) Social Security Account No. 215-24-1380

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1895

8. AGE: Years	Months	Days	If less than one day
51	7	27	hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Legal Candy Co

FATHER 12. Name Samuel Thomas Johnson

13. Birthplace Kentucky

MOTHER 14. Maiden Name Fanny Cloy Jones

15. Birthplace Kentucky

16 (a) Informant Elmer Johnson

(b) Address 624 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 E. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Sept 19 46 to 10 Sept 19 46, and that I last saw h e alive on 10 Sept 19 46.

Immediate cause of death: Cerebral hemorrhage — Duration 3 hrs

Due to hypertension — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Silverfield M.D.

Address 714 E. Preston St Date signed 11 Sept 46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43694 BALTIMORE CITY HEALTH DEPARTMENT G43694
CERTIFICATE OF DEATH 137a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-4
(c) Hospital or institution:
~~JOHNS HOPKINS HOSPITAL~~
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 East Oath ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country NORTH AVE

3 (a) FULL NAME Ahmed Hassam
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ~

4. Sex Mak | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Fehima
6 (c) If alive, give age 7 years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 52 | Months | Days | If less than one day hr. min.
9. Birthplace Palestine (Town, county, and state)
10. Usual Occupation Peddler
11. Industry or business

FATHER 12. Name Hassock Hassam
13. Birthplace Palestine
MOTHER 14. Maiden Name Chauffe ?D
15. Birthplace Palestine

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk
Location Taylor Ave.
18 (a) Funeral director Krause Funeral House
(b) Address 216 N. Charles St.
19 (a) (Date rec'd by registrar) (b) Huntington Woodlawn, Md. Registrar
SEP 13 1946

MEDICAL CERTIFICATION
20. DATE OF DEATH Sept 11 1946 at 2 07 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1946 to Sept 11 1946 and that I last saw him alive on Sept 11 1946
Immediate cause of death Uremia — Duration
Due to post operative shock & hemorrhage — 8 days
Due to Trauma - without reaction
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Sept 4.
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature Willard E. Brittain
Address Johns Hopkins Hosp. Date signed 9/13/46

X

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G43695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

G43695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 791 George St.
(c) Hospital or institution:
17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 791 George St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Mary J.

6 (c) If ever, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10. 1885

8. AGE: Years 61 Months 0 Days 0 If less than one day hr. min.

9. Birthplace Parksley, Va.,
(State, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Harry Clayton

13. Birthplace Va.,

MOTHER 14. Maiden Name Jane Kinsley

15. Birthplace Va.,

16 (a) Informant Mrs. Geneva Montague

(b) Address 1431 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna. Ave.,

19 (a) (Date rec'd by registrar) (b) Huntington Williamson, M.D.

SEP 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1946 6:50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 10 1946 to Sept 10 1946 and that I last saw h[illegible] alive on Sept 10 1946. The immediate cause of death was

Cerebral Hemorrhage — Duration 10 M

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1501 Penn Date signed 9/13/46

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G43696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 147D

G43696 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Seminary Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Lutherville Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Cruz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife Emilio Cruz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1925

8. AGE: Years	Months	Days	If less than one day
20	10	25	hr. min.

9. Birthplace Lutherville, Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Edward Sankey.
13. Birthplace Amherst Co, Va.

MOTHER
14. Maiden Name Francis Gordon.
15. Birthplace Balto. Co. Md.

16 (a) Informant Emilio Cruz
(b) Address Seminary Ave, Lutherville

17 (a) — (Burial, cremation, or removal) (b) Date thereof Sept 46. (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest.
Location Towson, Md.

18 (a) Funeral director Mrs. Jas. H. Holland.
(b) Address 1631 Druid Hill Ave.

19 (a) SEP 13 1946 (Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1946, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to 19__, and that I last saw h alive on 9-10 1946

Immediate cause of death	Duration
Acute Cardiac Failure Embolism (Pulmonary)?	
Due to Pregnancy — Undelivered (28 wks)	
Due to Ruptured Membranes (4 days duration)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Revell M.D.
Address 601 N Carrollton Ave Date signed 9/11/46

G43697. BALTIMORE CITY HEALTH DEPARTMENT G43697. Registered No.

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Whitelock St.
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Whitelock St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Maggie Greenwell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife Joseph Greenwell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Gordonsville, Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Francis Winkey
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Georgianna Richardson
15. Birthplace Gordonsville, Va.

16 (a) Informant Minerva Washington
(b) Address 1216 Whitelock St.

17 (a) — (Burial, cremation, or removal) (b) Date thereof 9-13-46 (month) (day) (year)
(c) Cemetery or crematory Cylvester Memorial P.K. Location Baltimore, Maryland

18 (a) Funeral director Archibald A. Hodder
(b) Address 2101 McCulloh St, Balto, Md.

19 (a) — (Date received by registrar) SEP 13 1946 (b) Registrar Huntington Williams

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1946, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1946, to 9/11 1946, and that I last saw her alive on 9/11 1946.

Immediate cause of death: Myocardial Degeneration — Duration —
Due to Hypertensive Heart Disease —
Due to —
Other Conditions none —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature J. Franklin Phillips
Address 543 Penna. Ave Date signed 9/12/46

J. Franklin Phillips

G43698 Pearson

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

G43698 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 S. Paca St
(c) Hospital or institution:
22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 S Paca
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Pearson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1875

8. AGE: Years 71 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Price
13. Birthplace Va

MOTHER 14. Maiden Name Mary Ella
15. Birthplace Va

16 (a) Informant Eddie Pearson
(b) Address 641 S. Paca

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-46 (month) (day) (year)
(c) Cemetery or crematory Earlington Heights
Location A.A. Co. Md

18 (a) Funeral director Josiah L. Burnett Inc
(b) Address 108 W Montgomery St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15a SEP 13 1948 Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1946, at 12 01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1946 to Sept 10 1946 and that I last saw he alive on Sept 9 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1802 Penna Ave Date signed 9-12-46

G43699 BALTIMORE CITY HEALTH DEPARTMENT G43699

CERTIFICATE OF DEATH 1216

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Woods, Maggie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	Negro	Widow

6 (b) Name of husband or wife John Woods
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1877

8. AGE: Years	Months	Days	If less than one day
68	10	10	hr. min.

9. Birthplace Chester, S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

BOTHER / FATHER
12. Name Jerry Degraffinreid
13. Birthplace Chester, S. C.

MOTHER
14. Maiden Name Nancy
15. Birthplace Chester, S. C.

16 (a) Informant Sumter Woods
(b) Address 1322 Argyle Ave
17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Sept. 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Chester S.C.
Location
18 (a) Funeral director Mrs Katie D. Wilkerson
(b) Address 322 W. Schroeder St
19 (a) SEP 13 1946 (Date rec'd by registrar) (b) Huntington Williams, Md.

VS 180

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Sep- 1946. 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4- 1946. to 9-8- 1946.
and that I last saw her alive on 9-8- 1946

Immediate cause of death Uremia — Duration 3 days duration

Due to Chronic Glomerulo Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald M. D.
Address 844 N. Carey St. Date signed 9-12-46

X

G43700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G43700

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3505 E. Fayette St.
(c) Hospital or institution: 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 E. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE EUGENE WELLSLAGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Elsie Thurlow Wel[illegible]
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 1/19/872

8. AGE: Years	Months	Days	If less than one day
74	7	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Fireman - ret. 22yrs.
11. Industry or business City of Baltimore

FATHER
12. Name George E. Wellslager
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary McAbee
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Elsie Wellslager
(b) Address 3505 E. Fayette St. - 24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

SEP 13 1946
(Date rec'd by registrar)

19 (a) [illegible] (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1946 to Sept 10 1946; that I last saw h[illegible] alive on Sept 10 1946.

Immediate cause of death	Duration
Cardio Vascular	2
Disease	
Due to Arterio Sclerosis	2
and Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. J. Sander M. D.
Address 100 N. Mullen Ave Date signed 9/12/46

VS 150

G43701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43701
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 E. Pratt Street
(c) Hospital or institution: 2-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? NB (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA CAROLINE BENNETT

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Usher B. Bennett
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1873

8. AGE: Years	Months	Days	If less than one day
72	9	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Horn
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Louis Wyble - daughter
(b) Address 103 S. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/43 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Sep 12 1946 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1946 2:30 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from March 17 1945 to Sept 12 1946 and that I last saw h[illegible] alive on Sept 11 1946.

	Duration
Immediate cause of death: Coronary Thrombosis	1 day
Due to: General Arteriosclerosis	5 yrs
Due to: Chronic Myocarditis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 129 S. Broadway Date signed 9/12/46

VS 150

G43702

500544.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G43702 Registered No.

16-3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 12-25-06

8. AGE: Years	Months	Days	If less than one day
39	8	16	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Johnny Harris
13. Birthplace S. C.

MOTHER
14. Maiden Name Mattie Reed
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/46 (month) (day) (year)
(c) Cemetery or crematory Ridgeland S.C
Location Ridgeland S.C.
18 (a) Funeral director Geo. B. Kilson
(b) Address 1303 Pennsylvania Ave
19 (a) SEP 13 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

28. DATE OF DEATH Sept. 11 1946 at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946, to Sept. 11 1946 and that I last saw him alive on Sept. 11 1946

Immediate cause of death
CEREBRAL HEMORRHAGE — Duration 1 day
Due to HYPERTENSION — 2 yrs
Due to NEPHRITIS — 3 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Douglas H. Conrad
Address Johns Hopkins Date signed 12 Sept 1946
M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Geo Harris X

G43703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G43703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916- Arlington Avenue (If rural give location)
(e) Citizen of foreign country? N (Yes or No) If yes, name country

3 (a) FULL NAME DELMORE SMITH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1919

8. AGE: Years	Months	Days	If less than one day
27 ?	1		hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Ernest Smith

13. Birthplace Va.

MOTHER 14. Maiden Name Priscilla Smith

15. Birthplace Va

16 (a) Informant John Rice

(b) Address 01372 N. Arlington Stockton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)

(c) Cemetery or crematory Lillian Va

Location Lillian Va

18 (a) Funeral director Geo. W. Kelly

(b) Address 1303 Pleasant St

19 (a) SEP 13 1946 (Date rec'd by registrar) (b) Huntington Baltimore Md.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946 xx, at 4 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of abdomen perforating ileum artery & traverse mesentery

Due to

Other Conditions Wounds of intestines & (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death fill in the following:

(a) Date of injury 9-9-46 at 11.05 A. M.

(b) Where did injury occur? outside Sharp & Hamburg Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Firearm

23. Signature Homer L. Wallis, M.D. Medical Examiner.

Date signed 9-10-46

43704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43704
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 547 Mosher St.
(c) Hospital or institution:
14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 547 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Ann Grimes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months . | Days . | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Miss Dorothy Grimes
(b) Address 547 Mosher Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/15/46 (month) (day) (year)

(c) Cemetery
Location Lancaster Co. Va.

18 (a) Funeral director C. Halstead
(b) Address 918 Druid Hill Ave.

19 SEP 13 1946
(Date rec'd by registrar) Hunter for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946, to Sept 12 1946, and that I last saw h[illegible] alive on Sept 12 1946.

Immediate cause of death Cardio Vascular Disease — Duration 1 yr.

Due to Cerebral Hemorrhage — 6 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Williams Troy M. D.
Address 1944 Pennsylvania Ave Date signed 9/13/46

X

VS 150

correct age is especially important. Physicians: please write the

G43705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43705
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 742 S. Conkling St.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 742 S. Conkling St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F. Dietz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/80

8. AGE: Years	Months	Days	If less than one day
66	11	23	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business Self

FATHER
12. Name Hypolitus Dietz
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Stark
15. Birthplace Germany

16 (a) Informant Mary Dietz
(b) Address 742 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Belair Rd.

18 (a) Funeral director Kelly & Zeith
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1946 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1946 to 9/11 1946 and that I last saw h.[illegible] alive on 9/10 1946.

Immediate cause of death	Duration
Cerebral accident	11 days
Due to Hypertension Cardio-Vascular Disease	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. Flannigan M. D.
Address 3503 Fait Ave Date signed 9-12-46

G43706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G43706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Lancaster St
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Lancaster St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ludwig ~~Jaworski~~ JAWORSKI

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1857

8. AGE: Years	Months	Days	If less than one day
89 90	1	7	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Tool Grinder
11. Industry or business

FATHER
12. Name ? Jaworski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Leon Jaworski
(b) Address 1605 Lancaster St.

17 (a) Burial (b) Date thereof 9-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Balto., Md.

18 (a) Funeral director Henry Sauder & Son, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar
SEP 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1946, at 4 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic CV disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. F. Schmidt M.D.
Medical Examiner.
Date signed 9/14/46

(over)

G43707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 872

G43707
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland and Raynor Balto 16.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-12
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 N. Chapel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Ballantine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Ballantine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 1908

8. AGE: Years	Months	Days	If less than one day
38	4	29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Taxi Cab Co.

FATHER
12. Name Alexander Ballantine
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Saunders
15. Birthplace Maryland

16 (a) Informant Mrs Margaret Ballantine
(b) Address 1721 N. Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Catonsville Md

18 (a) Funeral director Gilbert Funeral Home
(b) Address 2008 Eutaw St.

19 (a) Date received SEP 13 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept 1946, at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 August 1946 to 12 Sept 1946, and that I last saw him alive on 12 Sept 1946.

Immediate cause of death: Respiratory Failure — Duration: 10 min.

Due to Operation for Left Lumbo dorsal sympathectomy

Due to Right Ventricular Failure Pulmonary Congestion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12 Sept 46

Major findings of operation: Left Lumbo dorsal sympathectomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J W Bell M. D.
Address Date signed

VS 150

G43708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G43708 Registered No.

Please write the causes of death clearly and legibly. Physicians: please see that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-2
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 Washington Blvd. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM GRIFFIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 20, 1897

8. AGE: Years	Months	Days	If less than one day
49	4	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Copper Co.

FATHER
12. Name Wm. Griffin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Rae Rice
15. Birthplace Maryland

16 (a) Informant John A. Griffin
(b) Address 1326 Poplar Ter.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2001 Orleans St.

19 (a) (Date rec'd by registrar) (b) Baltimore, Md.

SEP 13 1946 Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1946 8:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1946 to 9-10 1946 and that I last saw him alive on 9-10, 1946

Immediate cause of death Chronic glomerular nephritis — Duration

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Markley, M.D.
Address Bon Secours Hosp Date signed 9-10-46

X

G43709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

G43709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 3/4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD TOWNSLEY

3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1892

8. AGE: Years	Months	Days	If less than one day
53	9	14	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Helper - Open Hearth
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Henry Townsley
13. Birthplace Penna

MOTHER
14. Maiden Name Emma Slaymaker
15. Birthplace Penna

16 (a) Informant Mrs Edith Rackwitz
(b) Address 708 Old Lancaster

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Actoria
Location Coatesville, Pa.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2028 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

VS. 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1946 at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Multiple incised wounds of neck, arms and chest

Due to

Other Conditions Mercury bichloride poisoning.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-10-46 at Approx. 5 A. M.
(b) Where did injury occur? 1218 St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inflicted wounds with sharp Instruments (Knife & Razor)
23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 9-11-46

FEB 12 Huntington Williams, M.D.

G43710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43710 Registered No.

Please write the causes of death clearly and legibly. Cause of death is especially important. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2653 Maryland Ave.
(c) Hospital or institution:

12-16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2653 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Dare Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife E. Fontaine Dare
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug. 12 - 188[illegible]

8. AGE: Years	Months	Days	If less than one day
60	10	0	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Chief Guard
11. Industry or business Natural Chemical Co.

FATHER
12. Name John Dare
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha Murphy
15. Birthplace Centreville - Md.

16 (a) Informant E. Fontaine Dare
(b) Address 2653 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Ave.

18 (a) Funeral director John C. Milburn
(b) Address 2135 E. Oliver St.

19 (a) Date received by registrar SEP 13 1946 (b) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1946; at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1946 to 9/12 1946, and that I last saw h[illegible] alive on — 19—.

Immediate cause of death Coronary occlusion — Duration

Due to Coronary sclerosis

Due to Hypertension Cardiac myocardial disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Trumbauer Jr. M. D.
Address 14 E. Eager St Date signed 9/13/46

(over) X

G33711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G33711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 North Rosedale Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 North Rosedale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. SMITH

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife Charles Smith
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 10-10-1865

8. AGE: Years	Months	Days	If less than one day
80	11	2	********** hr. ____ min.

9. Birthplace Carliale, Pa. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name John Bosler
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa.

16 (a) Informant Mrs. Frank J. Starke
(b) Address 3 North Rosedale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 14 Sept 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director [illegible]
(b) Address 1300 Eutaw Place...

19 (a) Sep 13 1946 (b) Huntington Williams, M.D.
(Date received by Registrar)

SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept. 1946 19 at 12:30P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1946 to 9/12 1946 and that I last saw her alive on 9/12 1946

Immediate cause of death Bronchopneumonia Duration 1 wk

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address Wilkens Ave. Date signed 9/13/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43712

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 167

G43712 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25 East Pratt Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Lake Montebello Terrace. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (CONCETTA) CONSTANCE A. CATANZARO

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1904

8. AGE: Years	Months	Days	If less than one day
41	10	12	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Catanzaro Fruit Co.

FATHER
12. Name August Catanzaro
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Purpura
15. Birthplace Italy

16 (a) Informant Mrs. Mary L. DiStefano
(b) Address 2109 Lake Montebello Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed SEP 14 1946 (Registrar) Huntington Williams

VS 191 SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1946, at 7.35 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage due to incised wound of neck.
Due to
Other Conditions Fractured skull
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-46 at approx. 3 p. M.
(b) Where did injury occur? 25 East Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury sharp instrument.
23. Signature Howard J. Thullen M.D. Medical Examiner.
Date signed 9-12-46

G43713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G43713
Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Ferndale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Ferndale Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Richardson

3 (b) If veteran, name war: none
3 (c) Social Security Account No. no

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine Richardson
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan 23 1880

8. AGE: Years 66 | Months 7 | Days 19 | If less than one day: hr. min.

9. Birthplace Wakefield Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Richardson
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Richardson
15. Birthplace Virginia

16 (a) Informant Mr Edward Richardson (Son)
(b) Address 6713 Windsor Mill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 13 1946 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION 11 45 P

20. DATE OF DEATH Sept. 12 1946, at [illegible] M

21. I certify that death occurred on the date above stated that I attended deceased from 1939 to Sept 12 1946.
and that I last saw him alive on Sept 12 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 3 Hrs
Due to Chronic Myocardial Degeneration — 16 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation no operation
Major findings of operation:
of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua H Armacost M. D.
Address 6419 Windsor Mill Rd Baltimore-7 Date signed Sept 12 1946.

VS 150

Printing for Williams, M.D.

G43714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G43714

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 58

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto. 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 Paul + 33 rd St. Bankford Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILMA BERNAYS SHIPLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	No	F	W	

6 (b) Name of husband or wife Paul G Shipley (dec.)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1887

8. AGE: Years	Months	Days	If less than one day
58	10	0	hr. min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name George Stanislaus Wislocki
13. Birthplace Poland

MOTHER 14. Maiden Name Lillie Clara Bernays
15. Birthplace Poland

16 (a) Informant daughter (Sylva)
(b) Address St Paul + 33rd St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 13 1946 SEP 14 1946 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1946, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1946 to 9/11 1946, and that I last saw her alive on 9/11 1946.

Immediate cause of death respiratory failure — Duration 23

Due to Metastatic Carcinoma

Due to Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J Marx M. D.
Address Mercy Hospital Date signed 9/14/46

G43715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G43715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gisela B. Pohl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Fritz Pohl
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21st 1874

8. AGE: Years	Months	Days	If less than one day
71	9	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Otto Benner
13. Birthplace Germany

MOTHER
14. Maiden Name Margarita Pipino
15. Birthplace Germany

16 (a) Informant Fritz Pohl
(b) Address 211 E. Biddle St.

17 (a) Burial (b) Date thereof 9/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.
(c) Filed by Huntington Williams M.D. Registrar

SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12th 1946, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 P, 1946 to Sept 12, 1946 and that I last saw h alive on Sept 12, 1946

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Muscular Dystrophy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund Goldberg M.D.

Address 622 W. North Ave Date signed 9/13/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G32716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE ST.
(c) Hospital or institution: ST JOSEPHS HOSP'L

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MO 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 W Lorraine
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. GETTINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife MARIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-72

8. AGE: Years	Months	Days	If less than one day
74	8	12	hr. min.

9. Birthplace Penna
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Muth Bros.

FATHER
12. Name Herman Gettinger
13. Birthplace Un Known

MOTHER
14. Maiden Name Johanna Raider
15. Birthplace Un Known

16 (a) Informant Mrs Marie Gettinger
(b) Address 321 W. Lorraine Ave

17 (a) Burial (b) Date thereof 9/14/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Filed by registrar) Registrar

SEP 13 1946
Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1946 to 9-12 1946 and that I last saw him alive on 9-12 1946.

Immediate cause of death CARDIAC FAILURE — Duration

Due to ARTERIOSCLEROTIC HYPERTENSIVE-RENAL

Due to DISEASE

Other Conditions FRACTURED HIP
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-23-46 at M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury Fell to floor from chair

23. Signature John B Wells M. D.
Address St Jos Hosp Date signed 9-12-46

Howard F. Mussina, M.D.

SEP 14 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13747 1

BALTIMORE CITY HEALTH DEPARTMENT

97390 CERTIFICATE OF DEATH 13B Registered No. C13717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-9-20
(e) Length of stay in Baltimore (yrs., mos., or days) 17-9-25

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1928

8. AGE: Years 17 Months 9 Days 25 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business South Balto. Gen. Hosp.

FATHER
12. Name Turner Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Isebel Jackson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calv. Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) Date received by local registrar SEP 12 1946 (b) Huntington Williams M.D. Registrar

SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20, 1945 to Sept. 10 1946 and that I last saw her alive on Sept. 10 1946

Immediate cause of death: Pulmonary edema — Duration: 3 hrs

Due to: Pulm. Tuberculosis — 1 yr.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 9-9-46

Major findings of operation: as a basis

of autopsy: " "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orsatt M.D.
Address Balto. City Hosp. Date signed 9-9-46

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G43718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 170 C

Registered No. G43718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 W. 8th St. Brooklyn, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH DUNTON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1931

8. AGE: Years	Months	Days	If less than one day
15	4	4	hr. min.

9. Birthplace Medford - Mass.
(Town, county, and state)

10. Usual Occupation School girl

11. Industry or business

FATHER
12. Name Seaton P. Dunton
13. Birthplace Virginia

MOTHER
14. Maiden Name Ruth Walker
15. Birthplace Virginia

16 (a) Informant Ruth W. Dunton
(b) Address 101 - 8th Ave - Brooklyn Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 46 (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location Anne Arundel County

18 (a) Funeral director Wendell E. Humphreys
(b) Address 6067 Harford Ave

SEP 14 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1946, at 10.10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull

Due to

Other Conditions Multiple bruises & bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-46 at approx. 8.10 p.m.
(b) Where did injury occur? Ritchie Highway a.a.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto while riding bicycle

23. Signature Howard J. Murphy M.D.
Medical Examiner.

Date signed 9-12-46

G43719 BCH G63224 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1579 G43719

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Adms
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 RAVENWOOD AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES H. Baby Boy CAMPBELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1946

8. AGE: Years	Months	Days	If less than one day
—	1	8	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name WILLIAM S CAMPBELL
13. Birthplace W. VA.

MOTHER
14. Maiden Name RITA STARKLOFF
15. Birthplace MD.

16 (a) Informant WILLIAM S. Campbell
(b) Address 3405 Ravenwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 16 46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location

18 (a) Funeral director L. J. Ruck
(b) Address Balto. Md

19 (a) SEP 13 1946 (Date received by Registrar) Huntington Williams, M.D.
SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1946, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1946 to Sept. 13 1946, and that I last saw him alive on 9-13 1946.

	Duration
Immediate cause of death Circulatory Collapse	
Due to Partial intestinal obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-29-46
Major findings of operation: Pyloric stenosis, congenital
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B. Workman M. D.
Address Univ. Hosp. Date signed 9-13-46

G33720

AB- 104415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓467

Registered No. G33720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 N. Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilmer Duffy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Pearl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1890 or 1891

8. AGE: Years	Months	Days	If less than one day
54 ~~yrs~~	8	17	hr. min.

9. Birthplace N.Y.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16. 1946 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantley ave
(Name, address, and license number) Huntington Woods

SEP 13 1946

SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11- 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10- 1946, to 9-11 1946, and that I last saw him alive on 9-10 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Carcinoma of rectum. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. L. Sills
Address Balto. City Hospitals Date signed 9/13/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43721

BALTIMORE CITY HEALTH DEPARTMENT X G43721 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Oella
(If outside city or town limits, write RURAL and give town)
(d) Street No. 56 Oella Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Joseph Nelson Hoff

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-6016

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna C. Hoff
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) April 1, 1912.

8. AGE: Years	Months	Days	If less than one day
34	5	10	hr. min.

9. Birthplace Oella, Balto Co., Md.
(Town, county, and state)
10. Usual Occupation Mill Worker.
11. Industry or business Woolen Mills.

FATHER
12. Name Joseph Nelson Hoff
13. Birthplace Virginia

MOTHER
14. Maiden Name Nettie Kelfaugh
15. Birthplace Maryland

16 (a) Informant Mr. Robert Ball
(b) Address Oella, Maryland.

17 (a) Burial (b) Date thereof Sept. 14, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd Cemetery
Location Ellicott City, Maryland
18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Maryland.
SEP 13 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19, 1946 19 , at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 19 46 to Sept 11 19 46, and that I last saw h. alive on Sept 11 19 46

Immediate cause of death	Duration
Malignant Hypertension	
Due to (2) Uremia	
Due to (3) Acute Pulm. Edema	
Due to (4) Terminal Pneumonia	
Other Conditions (4) Hypertensive C.V.D.	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy Same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature R. S Bauer M. D.
Address Univ. Hospital Date signed 9-11-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only approved abbreviations.

VS 180

SEP 14 1946

X

G43722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G43722 Registered No.

please write the causes of death clearly and legibly. Physicians: please see that the items are correct as to accuracy. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Nyman Park Drive
(c) Hospital or institution:
U.S.Marine Hospital,Baltimore,Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County - - -
(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Graydon Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Benham, Wales Alfred

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wh	--- Mar.

6 (b) Name of husband or wife Alice Benham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1886

8. AGE: Years	Months	Days	If less than one day
60	6	18 17	hr. min.

9. Birthplace Oakland, California
(Town, county, and state)
10. Usual Occupation Rear Adm.-Retired
11. Industry or business ---

FATHER 12. Name Thomas Benham
13. Birthplace London

MOTHER 14. Maiden Name Ella Wales
15. Birthplace Toledo, Ohio

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16-46 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat'l Cem.
Location Arlington Va.

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St.

19 (a) Filed SEP 14 1946 (b) Registrar Huntington Williams, M.D.
SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.12 1946, at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug.28 1946, to Sept.12 1946, and that I last saw him alive on Sept.12 1946.

	Duration
Immediate cause of death Pneumonia left lower lobe	24 hrs.
Due to (2) Right sided heart failure	1 hr.
Due to (3) Pulmonary edema	24 hrs.
(4) Tracheal esophageal fistula	UNKNOWN
Other Conditions (5) Carcinoma of esophagus	1 yr.

(Include pregnancy within 3 months of death)
Date of operation 9/12/46 Gastroscopy
Major findings of operation: ---
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 9/13/46.

43723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 43723

1. PLACE OF DEATH: (a) Baltimore City, Maryland — Clayhurst Home
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) Baltimore City
(c) City or town 134 Meadow Rd (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Samuelson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Oscar Samuelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2-1860

8. AGE: Years 86 Months -8 Days 10 If less than one day hr. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name M. Dwyer
13. Birthplace Michigan

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr Stein Kraus
(b) Address 134 Meadow Rd (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) SEP 1946 Huntington Williams M.D.
(b) (Signature of registrar) Registrar

VS SEP 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1946 at 11 p M

21. I certify that death occurred on the date above stated, that I attended deceased from July 20 1946 to Sept 12 1946 and that I last saw h[illegible] alive on Sept 12 1946

Immediate cause of death: Cerebral thrombosis — Duration
Due to Cerebral sclerosis
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Calhoun Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43724

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH √124a

Registered No. G43724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Perrin
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Adams Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife ~~Lucy~~ Lucy Williams Jenkins
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 1-30-99

8. AGE: Years	Months	Days	If less than one day
47	7	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation fisherman
11. Industry or business

FATHER
12. Name Robert Lee Jenkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Lee Hall
15. Birthplace Virginia

16 (a) Informant Spouse
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 14 46 (month) (day) (year)
(c) Cemetery or crematory
Location Gloucester Virginia

18 (a) Funeral director Philip Hermitt Sons
(b) Address 2024 Orleans St

19 (a) SEP 14 1946 Burial permit issued (b) Registrar Williamsburg Va

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1946, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1946, to 9-13 1946, and that I last saw h[illegible] alive on 9-12 1946

Immediate cause of death: Cirrhosis of liver — Duration:
Due to: Alcoholism
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip D. Wagley M. D.
Address Johns Hopkins Hosp Date signed 9-13-46

correct age is especially important. Physicians: please write the causes of death clearly and

VS 150

X

G43725 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G43725

CERTIFICATE OF DEATH ✓170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 W. East Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbert ~~Wilbur~~ ~~Rollins~~ Rawlings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1941

8. AGE: Years	Months	Days	If less than one day
5			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER 12. Name Cleane Rawlings

13. Birthplace Va

MOTHER 14. Maiden Name Gertrude Johnson

15. Birthplace N. C.

16 (a) Informant Margaret Johnson

(b) Address 136 W West Street

17 (a) Burial (b) Date thereof Sept 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A A Co Md

18 (a) Funeral director Sarah L Brown Son

(b) Address 106 W Montgomery St

19 (a) SEP 14 1946 (b) Huntingtown Williams, M.D.
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1946 at 5.27 PM

21. I certify that I took charge of the remains described above, held an inspection & inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture & dislocation of Cervical vertebra

Due to

Other Conditions Multiple Fractures.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-46 at 5 p. M. 23/1
(b) Where did injury occur? Leadenhall St. 50 ft. North Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury? Pedestrian struck by auto

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-12-46

G33726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G33726

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 Winans Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Winans Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Cathcart

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	Female	White	Widowed

6 (b) Name of husband or wife Joseph W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1855

8. AGE: Years	Months	Days	If less than one day
91	7	3	hr. min.

9. Birthplace Westminster, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Airhart Winters
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Catherine Everhart
15. Birthplace Manchester Md.

16 (a) Informant Mrs. Lowell Henneberger
(b) Address 806 Winans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) Filed SEP 14 1946 (b) Registrar Huntington Williams (Signature of Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 12 1946, at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1946 to 9/12 1946. and that I last saw h[illegible] alive on 9/11 1946.

Immediate cause of death: Cerebral hemorrhage — Duration: 14 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Leitch M. D.
Address 340 Tunbridge Rd Date signed 9/13/46

VS 150

3727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G43727

Please write the causes of death clearly and legibly. Physicians: please see that information as to age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loyola Bayview Hts.
(c) Hospital or institution: Bon Secours Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4152 Keenan Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Helen M. Sunderland

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife E. Wade
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 14 1906

8. AGE: Years	Months	Days	If less than one day: hr.	min.
40	5	30		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name Charles Zink
13. Birthplace Lithuania

MOTHER
14. Maiden Name Louise Beskis
15. Birthplace Lithuania

16 (a) Informant Mr. E. Wade Sunderland
(b) Address 4152 Keenan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location 4430 Belair Road

18 (a) Funeral director John A. Gawler & Son
(b) Address 901-03 Hollins St

19 (Date rec'd by registrar) SEP 14 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Sept. 1946, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Sept. 1946 to 13 Sept. 1946 and that I last saw h.er alive on 13 Sept. 1946

Immediate cause of death	Duration
Pulmonary embolism	
Due to Post Operative	
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation 7 Sept 46
Major findings of operation: Uterus Fibroids + Chr. Appendicitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature E. H. Nottle Jr. M.D.
Address Bon Secours Date signed 13 Sept 46

VS 150

G43728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G43728

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNA KATZENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: David Katzenberg
6 (c) If alive, give his ~~or her~~ years

7. Birth date of deceased (mo., day, yr.): Dec. 5 1887

8. AGE: Years: 58 | Months: 9 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Pittsburgh Pa. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: Samuel Brownskey,
13. Birthplace: Russia

MOTHER 14. Maiden Name: Dora Shulman,
15. Birthplace: Russia.

16 (a) Informant: Mr. David Katzenberg
(b) Address: 1812 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/46. (month) (day) (year)
(c) Cemetery: Chesed Shalom
Location: Balto. Md.

18 (a) Funeral director: Harris Sonneborn & Son
(b) Address: 1902 Eutaw Place

19 SEP 14 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1946 to Sept. 12 1946 and that I last saw h. alive on Sept. 12 1946.

	Duration
Immediate cause of death: Myocardial infarction	6 days
Due to: Coronary artery heart dis.	1 year
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Leonard E. Blumenthal M. D.
Address: W B & H Date signed 9/12/46

VS 150

G43729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G43729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 E. 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 E 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20-1875

8. AGE: Years	Months	Days	If less than one day
71	-	21	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Chester Kurley
13. Birthplace Va

MOTHER
14. Maiden Name Nancy Kurley
15. Birthplace Va

16 (a) Informant Susan Walker
(b) Address 208 E. 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 Date received SEP 14 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11-46 19 at 4 22 AM

21. I certify that death occurred on the date above stated, that I attended deceased from July 1, 1946 to Sept 11, 1946, and that I last saw h[illegible] alive on 9-10-46 19

Immediate cause of death
(a) Hypertension Heart Disease — Duration 2 yrs.

Due to

Due to

Other conditions
Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Adams,
Address 31 E 23rd St Date signed 9-12-46 M. D.

Correct age is especially important. Physicians: please write

VS 150

G43730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832a

L. Johns G43730 Registered No.

Write the causes of death clearly and legibly. Physicians: please write to correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 Llewelyn ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Llewelyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Cobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 16 1909

8. AGE: Years	Months	Days	If less than one day
37	5	23	hr. min.

9. Birthplace Alabam (Town, county, and state)
10. Usual Occupation Can't Known
11. Industry or business

FATHER
12. Name Lawrence
13. Birthplace Ala.

MOTHER
14. Maiden Name Mary Boldon
15. Birthplace Ala

16 (a) Informant Violet Reed
(b) Address 16 Elmore St. Pitts burgh Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 14 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) [illegible] (b) Huntington W Va

SEP 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946, at 8.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 4 1946 to Sept 9 1946 and that I last saw h[illegible] alive on Sept. 9 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Johns M.D.
Address 2829 Guilford Ave Date signed Sept 14 1946

X

G43731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

G43731 Registered No.

Please write the causes of death clearly and legibly; correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 S. Luzerne ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 S. Luzerne ave (If rural give district)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Cioseh or Mary Cioceh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm J. Cioseh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1896

8. AGE: Years 49 | Months 9 | Days [redacted] | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Joseph Cieslak
13. Birthplace Poland.

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Wm J. Cioseh
(b) Address 820 S. Luzerne ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17 46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director Marie E. Frankowski
(b) Address 1500 S. Kenwood Ave

19 (a) Date received by Local Registrar SEP 14 1946 (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1946, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1946 to Sept 12 1946, and that I last saw h[illegible] alive on 19

Immediate cause of death Coronary Thrombosis — Duration 3 days

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 9/13/46

JANUSZESKI X

G43732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43732 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 N. Carlton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Carlton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Lawson Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15 1869

8. AGE: Years 77 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Essex County, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Williams Winn.
13. Birthplace Essex Co. Va.

MOTHER
14. Maiden Name Jennie
15. Birthplace Essex County Va.

16 (a) Informant: Mrs. Charles A. Green
(b) Address 115 N. Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14 1946 (Month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs Kate R. Hilliard
(b) Address 2222 Schroeder St.

19 (a) SEP 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10, 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Sept 10 1945 to Sept 10 1946 and that I last saw h[illegible] alive on Sept 9 1946.

Immediate cause of death: Cardio-renal vascular disease — Duration: one year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. L. Compere M. D.
Address 639 N. Carey St Date signed 9-12-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 150

G43733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G43733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 Reese St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson, Howard Douglas

3 (b) If veteran, name war	3 (c) Social Security Account No.		
WW 2	216-03-2006		
4. Sex	**5. Color or race**	**6 (a) Single, married, widowed, or divorced**	
M	col	married	

6 (b) Name of husband or wife Annie Milligan Wilson
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1904

8. AGE: Years	Months	Days	If less than one day
41	8	29	hr. min.

9. Birthplace Chatham, Va.
(Town, county, and state)
10. Usual Occupation Truck driver
11. Industry or business

FATHER
12. Name Peter Wilson
13. Birthplace Va.

MOTHER
14. Maiden Name Mirrousi L. Parker
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13 1946 (month) (day) (year)
(c) Cemetery or crematory National Cem. Balto. Md.
Location

18 (a) Funeral director Mrs. Kate R. Gallagher
(b) Address 922 W. Lafayette St.

19 (a) [illegible] Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946 2:18 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1946 to Sept. 10 1946 and that I last saw him alive on Sept. 10 1946

Immediate cause of death	Duration
Pneumonia	
Due to Bronchogenic Carcinoma	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Nelson Jr. M.D.
Address U.S. Marine Hosp. Date signed 9/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43734 BC# F 78529 BALTIMORE CITY HEALTH DEPARTMENT ✓ G43734 Registered No.

CERTIFICATE OF DEATH 33B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Pierce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Quentin Butler Jr. ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1943

8. AGE: Years 3 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Quentin W Butler Sr.
13. Birthplace Brooklyn Md

MOTHER 14. Maiden Name Bessie Wyts
15. Birthplace Balto. Md.

16 (a) Informant Quentin Butler
(b) Address 919 Pierce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sept 1946 at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Sept 1946 to 19 , and that I last saw h/ alive on 9 Sept 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Hyperthermia	
Due to Extreme Hydrocephalus following influenza	
Other Conditions Meningitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: Extreme hydrocephalus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. M. Crosby M.D.
Address Univ. Hosp Date signed 9 Sept

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43735 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 W Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dannie Rice Duvall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George Duvall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1881

8. AGE: Years	Months	Days	If less than one day
65	6		hr. min.

9. Birthplace Danville Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rice
13. Birthplace Danville Va.

MOTHER
14. Maiden Name
15. Birthplace Danville Va.

16 (a) Informant George E. Rice
(b) Address 1004 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Western Stars Cem
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 922 W. Schroeder St.

19 Date received by registrar SEP 14 1946 Hunter-Jon Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Sept 10 1946 and that I last saw he alive on Sept 10 1946.

Immediate cause of death Cardio Vascular disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Watts
Address 515 Gilmore Date signed 9/11/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43736

500422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43736
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 536 New Pittsburg Ave
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Mitchell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Brewster Mitchell
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 10-4-08

8. AGE: Years	Months	Days	If less than one day
37.	11	7	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Arthur Watson
13. Birthplace N. C.

MOTHER
14. Maiden Name Martha Stamer
15. Birthplace N. C.

16 (a) Informant Rosa
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1946 at 4.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1946, to Sept. 11 1946, and that I last saw her alive on Sept. 11 1946.

Immediate cause of death (a) Uremia and Hypertensive encephalopathy — Duration 6 hours

Due to Severe malignant hypertension — Duration 1 yr. 2 mo

Due to — Duration

Other Conditions Hypertensive CV disease — Duration 5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. J. Davis
Address Johns Hopkins Hosp. Date signed 9/11/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43737 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Calif. (b) County
(c) City or town Los Angeles (If outside city or town limits, write RURAL and give town)
(d) Street No. 5239- Lincoln Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN B. ARMSTRONG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1909

8. AGE: Years	Months	Days	If less than one day
37	5	18	hr. min.

9. Birthplace Moneta, Calif., (Town, county, and state)
10. Usual Occupation Soldier
11. Industry or business U.S. Army

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant U.S. Army Records
(b) Address Aberdeen Proving Ground

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month, day, year)
(c) Cemetery or crematory Sawtelle Natl. Cem
Location Los Angeles, Calif.

18 (a) Funeral director Howard K. McComas Fdsr.
(b) Address Abingdon, Md.

19 (a) SEP 14 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946 at 11.20 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull
Intracranial hemorrhage

Due to

Other Conditions Terminal bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-46 at approx. 10 a.m. Balto. Co.
(b) Where did injury occur? Wash. Blvd. & Buttermilk Hill
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian in motor

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9-13-46

G43738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 E

Registered No. G43738

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 S. Chester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 S. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Adam Wachowiak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6-1900

8. AGE: Years	Months	Days	If less than one day
45	9	5	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER 12. Name John N. Wachowiak
13. Birthplace Poland

MOTHER 14. Maiden Name Magdalena Barthowiak
15. Birthplace Poland

16 (a) Informant Rt. Rev. Msgr. Stanislaus Thekowski
(b) Address 408 S. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16. 46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 SEP 14 1946 (b) Burlington Williamsburg, Md.
(Date rec'd by Local Reg.) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1946 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Sept 11 1946 and that I last saw him alive on Sept 11, 1946.

Immediate cause of death	Duration
Malignant Hypertension	
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lenard Lumpowski M.D.
M. D.
Address 2539 Eastern Ave. Date signed

VS 150

X

G43739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G43739 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County 1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 841 West Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenora Page

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/22

8. AGE: Years 24 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Hunter

13. Birthplace North Carolina

MOTHER 14. Maiden Name Claudia Moore

15. Birthplace North Carolina

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/46 (month) (day) (year)

(c) Cemetery or crematory Greenville, N.C.
Location

18 (a) Funeral director Geo. H. Nelson

(b) Address 1303 Pleasant Mann St.

19 (a) SEP 14 1946 (b)
(Date received by Registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1946, at 10 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1946, to Sept 13 1946 and that I last saw her alive on Sept 13 1946

Immediate cause of death: Generalized tuberculosis
Due to: Tuberculosis of cerebral hemisphere

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: Yrs., months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. T. Davis

Address Johns Hopkins Hospital Date signed 9/13/46

X

G43740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G43740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) ever Yrs in

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Delmar (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George SULLIVAN

3 (b) If veteran, name war	3 (c) Social Security Account No. 716-01-6899

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elsie May Sullivan
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) August 4 1884

8. AGE: Years	Months	Days	If less than one day
58 (57)	1	10	hr. min.

9. Birthplace Delmar Delaware (Town, county and state)
10. Usual Occupation Freight Conductor
11. Industry or business Penna R.R.

FATHER
12. Name Isaac Sullivan
13. Birthplace Delmar Delaware

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elsie May Sullivan
(b) Address 711 Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Meth. Epis.
Location Delmar Delaware

18 (a) Funeral director John S. Miller Son
(b) Address 242 E. Olive St.

19 SEP 14 1946 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1946, at 1 25 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/14/46

G43741 Onew

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43741

CERTIFICATE OF DEATH 161a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Balto.~~
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3472 Parklawn Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Strunge

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 13, 1946
8. AGE: Years 0 Months 0 Days 1 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Strunge
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Gulas
15. Birthplace Balto

16 (a) Informant Joseph Strunge
(b) Address 3472 Parklawn Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Rd
18 (a) Funeral director Joseph Kaminska
(b) Address 66-7 Wash, Balto
19 1946 (b) Registered by Registrar
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1946, at 12:40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1946 to Sept 14 1946, and that I last saw h alive on Sept 14 1946.
Immediate cause of death Congenital Atelectasis — Duration Life
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature H. D. Gentry, M.D. M. D.
Address Mercy Hosp Date signed 9-14-4

VS 150

G43742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G43742
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St. Agnes Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4609 Edmondson Ave
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Caton Ave
(e) Citizen of foreign country? (If rural give location) No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Kepler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name George Funk

13. Birthplace Md.

MOTHER 14. Maiden Name Alice Willis

15. Birthplace Md.

16 (a) Informant Mrs Edwin Hearne

(b) Address Salisbury Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 1946 (month) (day) (year)

(c) Cemetery or crematory Reformed

Location Knoxville Md

18 (a) Funeral director C. H. Fuller Bro

(b) Address Brunswick Md

19 (a) 1946 (Date rec'd by registrar) (b) J. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1946 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death respiratory failure

Due to pulmonary embolus

Due to

Other Conditions ca of sigmoid,

(Include pregnancy within 3 months of death)

Date of operation Sept 9, 1946

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address St. Agnes Hosp Date signed Sept 17 46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G43743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

✓ G43743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2241 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2241 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Luther Tabb

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-20-6094

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Margaret L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1902

8. AGE: Years	Months	Days	If less than one day
44	7	22	hr. min.

9. Birthplace Gloucester Co. Va (town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER 12. Name Stapleton Tabb
FATHER 13. Birthplace Gloucester Co. Va
MOTHER 14. Maiden Name Carrie Brafton
MOTHER 15. Birthplace Gloucester Co. Va

16 (a) Informant Margaret L. Tabb
(b) Address 2241 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/1946 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Ivy Hall Va

18 (a) Funeral director Wm. George H. Hall & Son
(b) Address 1631 Druid Hill Ave

19 (a) SEP 15 1946 (Date rec'd by registrar) (b) Victor Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1946, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1946 to Sept 12 1946 and that I last saw him alive on Sept 12 1946

Immediate cause of death	Duration
Cerebral apoplexy	5 wks
Due to Cerebral arteriosclerosis,	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas H Pancoast M. D.
Address 1723 Druid Hill Ave Date signed Aug 4 9/14/46

VS 150

Cert age is especially important. Physicians: please write the causes of death clearly and legibly.

G43744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G43744

Registered No.

TN: 104339

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside the city or town limits, write RURAL and give town)
(d) Street No. 524 Pece St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Napolean Canty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Beulah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26th 1906

8. AGE: Years	Months	Days	If less than one day
40	0	16	hr. min.

9. Birthplace S.C (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Napolean Canty
13. Birthplace S.C

MOTHER
14. Maiden Name Brazulis Prignel
15. Birthplace S.C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Removal (b) Date thereof Sept 14 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Manning S. C.

18 (a) Funeral director Isaiah C Brown Son
(b) Address 1045 Montgomery St

19 (a) (b) Registrar
(Date rec'd by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12th 19 46, at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9th 19 46, to Sept 12/ 1946, and that I last saw h IM. alive on Sept 12/ 19 46

Immediate cause of death	Duration
Respiratory Failure	
Due to Congestive Heart Failure	
Due to Pulmonary Tuberculosis	
Other Conditions Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm R Kenborne M. D.
Address Balto City Hosp Date signed 9-13-46

X

G43745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G43745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton & Catas Ave.
(c) Hospital or institution: St. Agnes Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3131 Winds Falls Pkwy (If rural give location)
(e) Citizen of foreign country Germany (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Nora Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-2940

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1884

8. AGE: Years	Months	Days	If less than one day
62 60	5	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Sales Lady
11. Industry or business Hochild Kahn

FATHER
12. Name James W. Dixon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bettie ?
15. Birthplace Virginia

16 (a) Informant Florence Dixon
(b) Address 3131 Gwyns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) SEP 15 1946 (Date rec'd by registrar) (b) Washington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1946 at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1946 to 9-13 1946 and that I last saw h alive on 9-12 1946

Immediate cause of death	Duration
Peritonitis, acute	
Due to Carcinoma of rectum, perforating.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Hope Jr.
Address St. Agnes Hospital Date signed 9/14/46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G43746 BALTIMORE CITY HEALTH DEPARTMENT G43746
CERTIFICATE OF DEATH 107 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Cause of death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 Rosedale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Rosedale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William J. Kane

3 (b) If veteran, name war ***
3 (c) Social Security Account No. ****

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Anna R. Kane
6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) January 22 1860

8. AGE: Years 86 Months 2 Days 20 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name William F. Kane
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Elizabeth Bunnap
15. Birthplace Balto

16 (a) Informant J. Morita
(b) Address 1407 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) SEP 15 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1946, at 4 4. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1945 to 9/14 1946 and that I last saw h[illegible] alive on 9/12 1946.

Immediate cause of death: Bronchopneumonia — Duration 8 Days
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Robert A. Reiter M. D.
Address 3408 Windsor Ave. Date signed 9/14/46

G43747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935 G43747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 W. Camden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 130 W Camden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Leon Katz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 55 | Months | Days | If less than one day: hr. min.

9. Birthplace Lith (town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Gabriel Lick
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace Lith

16 (a) Informant: Julia Katz
(b) Address 130 W. Camden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-46 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

SEP 15 1946 (Date received by local registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17- 1946 at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1946 to 9/17 1946 and that I last saw him alive on 9/17 1946.

Immediate cause of death: Acute Coronary Thrombosis — Duration

Due to: Atherosclerotic CVHD

Due to: Coronary Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Appelfeld MD
Address 2511 Reisterstown Rd Date signed 9/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G43748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43748 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 No Dentelow St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 No Dentelow St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Shevitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Romania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Nathan Baltzman

13. Birthplace Romania

MOTHER 14. Maiden Name Rebecca

15. Birthplace Romania

16 (a) Informant Jacob Shevitz

(b) Address 1900 No Dentelow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-46 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Wash. Blvd.

18 (a) Funeral director Jack Feuss Inc

(b) Address 1439 E. Balto St

19 (a) 1946 (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14-1946, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Sept. 14 1946, and that I last saw h er alive on Sept. 14 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerosis, Aortic	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W. E. Needle, MD
23. Signature
Address 731 X - W. North Ave Date signed 9/14/46 M D

VS 150

X

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G43749 Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 S. Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 S Hanover St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Meister

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Fredrick Meister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10-1870

8. AGE: Years 76 | Months 2 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business —

FATHER
12. Name Valentine Haas
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Cornelia Jackson
15. Birthplace Balto Md

16 (a) Informant Mr. Bruning
(b) Address 1706 S Hanover St

17 (a) Burial (b) Date thereof Sept 16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) Date received SEP 15 1946 (b) Registrar
(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION 4-30

20. DATE OF DEATH Sept 12 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to Sept 12 1946 and that I last saw h alive on Sept 12 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days
Due to Hypertension — 4 yrs
Due to Arteriosclerosis — 6 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Haas Coons M. D.
Address 1706 S Hanover St Date signed

VS 150

X

G43750

500556.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

Registered No. G43750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2. W. University Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Goldsborough Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Imogene B. Morgan
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 6-28-84

8. AGE: Years	Months	Days	If less than one day
62	1 2	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Baltimore Salesbook Co.

FATHER
12. Name William Thomas Morgan
13. Birthplace VS

MOTHER
14. Maiden Name Hester Goldsborough
15. Birthplace Md

16 (a) Informant Recorde.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 9/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
North & Pa. Ave.
(b) Washington Village, Md.

19 (a) 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 14 1946 at 4.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept- 10 1946 to Sept-14 1946 and that I last saw h imalive on Sept -14 1946.

Immediate cause of death Shock	Duration
Due to Mesenteric Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/14/46
Major findings of operation: Mesenteric Thrombosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. C. Davis M.D.
Address Johns Hopkins Hospital (Date signed)

VS 150

X

correction is especially important. Physicians: please write the causes of death clearly and legibly.

G43751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 G43751

File No. ~~G43751~~

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Underlining the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 St. Martin's Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS E. BIDDISON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Amy D. Biddison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1870

8. AGE: Years	Months	Days	If less than one day
76	5	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired Real Estate
11. Industry or business

FATHER
12. Name Zachariah M. Biddison
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Amy D. Biddison
(b) Address 6 St. Martin's Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 15 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1946, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Sept 13 1946, and that I last saw him alive on Sept 13 1946

Immediate cause of death: Arteriosclerosis
Hyp2h Coronary Cardiac Insufficiency.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Loth M.D.
Address 6805 York Rd Date signed 9/13/46 M. D.

X

G43752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G43752
Registered No.

Please write the causes of death clearly and legibly. Exact age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN R. HACKNEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife M. Louise Epron Hackney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1853

8. AGE: Years	Months	Days	If less than one day
92	9	14	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Printer
11. Industry or business A. S. Abell Co.

FATHER
12. Name Wm. H. Hackney
13. Birthplace Balto.

MOTHER
14. Maiden Name Eleanor S. Hugg
15. Birthplace Balto.

16 (a) Informant Miss Elsie M. Hackney
(b) Address 2035 E. 31st St.

17 (a) Burial (b) Date thereof 9/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 15 1946 (b) Clinton Williams Registrar
(Date actually received)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1946, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 19 41 to Sept 11 1946; and that I last saw h alive on Sept 11 1946.

Immediate cause of death

	Duration
a Uremia	?
Due to a Arteriosclerosis & Nephritis	?
Due to b Diabetes Mellitus	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. W. Thomas M.D.
Address 315 Cleveland Date signed 9/17/46

G43753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G43753 Registered No.

Please write the causes of death clearly and legibly. Physicians; please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Bolton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edmonia Lawson

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife William A. Lawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1887

8. AGE: Years	Months	Days	If less than one day
58	9	10	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Ridgeway
13. Birthplace Va.

MOTHER
14. Maiden Name Rebecca Hance
15. Birthplace Va.

16 (a) Informant Miss Evelyn Lawson
(b) Address 237 E. 53rd St., New York City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received SEP 15 1946 (b) Harrington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1946, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1946 to Sept 13 1946 and that I last saw h[illegible] alive on Sept 13 1946.

Immediate cause of death Cardiac failure — Duration

Due to Rheumatic C.V.D. & mitral stenosis & fibrillation

Due to

Other Conditions Cancer mammae — accident
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Harley M. D.
Address Univ. Hosp. Date signed 9-15-46

VS 150

G43754

BALTIMORE CITY HEALTH DEPARTMENT ✓ G43754
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Boone St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris H. Swartz.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Fannie.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-83

8. AGE: Years 62 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Self

FATHER
12. Name Henry M. Swartz
13. Birthplace New York

MOTHER
14. Maiden Name Adeline Develbi
15. Birthplace Balto., Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew Friendship Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 15 1946 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 13 1946, at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1946, to Sept. 13 1946, and that I last saw him alive on Sept - 13 1946.

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Wagley M. D.
Address Johns Hopkins Hosp. Date signed 9-13-46.

VS 150

(over)

X

G43755 ✓ G43755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 116

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1536 W. Lanvale.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 W. Lanvale St.
(If rural give location)
(e) If foreign born, how long in U. S. A. [redacted] years

3 (a) FULL NAME Casper Napoleon Pigott.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma Pigott

6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) Nov 29 1890

8. AGE: Years 55 | Months 10 | Days 18. | If less than one day: [illegible] hr. [illegible] min.

9. Birthplace Baltimore City, Md
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business Undertaker

FATHER
12. Name George Pigott
13. Birthplace Oxford, Md.

MOTHER
14. Maiden Name Margaret Burley
15. Birthplace Maryland

16 (a) Informant Emma Pigott.
(b) Address 1536 W. Lanvale St.

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 9-15-46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus, Md.

18 (a) Funeral director Mrs. Geo. F. Holland
(b) Address 1631 Druid Hill Ave

19 (a) 9 15 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1946, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1946, to 9/12 1946; and that I last saw [illegible] alive on 9/12 1946.

Immediate cause of death: Acute Myocarditis — Duration: 2 days.

Due to: Gastro Enteritis — Duration: 1 day.

Due to: G.S.W. Abdomen — Duration: 2 days.

Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operation: Laparotomy
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible]

VS 3

G43756 103942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓G43756 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1088 Peach St. - 30 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Addie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, ? 1871

8. AGE: Years	Months	Days	If less than one day
75 ?	3 ?	? 5	hr. min.

9. Birthplace Ala. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Martin
13. Birthplace Ala.

MOTHER
14. Maiden Name ?
15. Birthplace Ala.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Isaiah D. Brown Sons
(b) Address 105 W Montgomery St

19 (a) 9.5.1946 (Date rec'd by Registrar) (b) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1946 at 10:50P

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21, 19 46 to Sept. 10, 46 and that I last saw h alive on Sept. 10 19 46.

Immediate cause of death Cerebro - vascular Accident. — Duration

Due to Arteriosclerotic C-V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation —

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto. City Hosp. Date signed 9-10-46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G43757
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 W Lee Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ (b) County ✓
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W Lee Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella Cooper
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓
4. Sex F
5. Color or race Col
6 (a) Single, married, widowed, or divorced. widowed ✓
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 10 1872
8. AGE: Years 74 Months 1 Days 2 If less than one day hr. min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation D
11. Industry or business
FATHER 12. Name Thomas Joyce
13. Birthplace Md
MOTHER 14. Maiden Name Ruth Jones
15. Birthplace Md
16 (a) Informant Mabel Cumberstache
(b) Address 615 W Lee Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 9 (day) 15 (year) 46
(c) Cemetery or crematory Mt Calvary
Location A R Co Md
18 (a) Funeral director Daniel O'Donnell Son
(b) Address 1086 W Montgomery St
19 (a) (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 19 , at 5:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1946 to Sept 12 1946 and that I last saw her alive on Sept 12 1946
Immediate cause of death Coronary Thrombosis — Duration
Due to Arteriosclerosis
Due to Myocardial Fibrosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the name to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W F Hamilton M. D.
Address 6 East Carrollton Ave Date signed 9-15-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

G43758 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G43758 Registered No.

Please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1350 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl March

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1946

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank P. March

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Edna E. Watts

15. Birthplace Baltimore, Md.

16 (a) Informant Mr Frank P. March

(b) Address 1350 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-46 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole

(b) Address 200 N. Longford St.

SEP 15 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1946, at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13, 1946, to Sept. 14, 1946, and that I last saw her alive on Sept. 14, 1946.

Immediate cause of death	Duration
Pulmonary atelectasis	
Due to	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stuart McG. Sessoms, M.D.

Address 2351 N. Charles St. Date signed 9/14/46

X

G43759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43a

G43759 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 1608 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Mildred Sherry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife NOAH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-46 (month) (day) (year)
(c) Cemetery or crematory Wash. Blvd
Location Wash. Blvd
18 (a) Funeral director Jack Leigh Inc
(b) Address 2100 Eutaw Pl.
19 (a) (Date rec'd) (b) Registrar

SEP 16 1946

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1946, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1946 to 9-15 1946, and that I last saw her alive on 9-15 1946.

Immediate cause of death	Duration
Cerebral Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Nyman
Address Sinai Hosp. Date signed 9-15-46 M. D.

X

G43760 Grave # 5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G43760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unidentified

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
?45			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business Unknown

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address
SEP 17 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946, at 10.20 A.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. Partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8/24/46

G43761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43761 Registered No.

Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 N Port St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank H. Sapp

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 218-05-2626

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha M.

6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Nov 14 1908

8. AGE: Years 37 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation: Experimental Dept

11. Industry or business: Glenn L. Martin Co.

FATHER
12. Name: William O. Sapp
13. Birthplace: Balto

MOTHER
14. Maiden Name: Bertha Dorsch
15. Birthplace: Balto.

16 (a) Informant: Bertha M. Sapp
(b) Address: 23 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/46 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave.

18 (a) Funeral director: H. W. E. Dipple & Sons
(b) Address: Gorsuch & Ann St.

19 (a) Date received: SEP 16 1946 (b) Registrar: Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1946 at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1946 to Sept 1946, and that I last saw h~~im~~ alive on Sept 13, 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 1/2 Hour

Due to: Unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Geo. B. Morris, M.D.

Address 448 N. Longwood St. M. D. Date signed 9-19-46.

By J. R. Davis, by Howard J. Morris, M.D.

G43762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G43762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loudon Park + Wadsworth Ave
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(d) Street No. 4203 ~~Wadsworth Ave~~ Maine Ave. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Fred. W. Klingelhofer.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alice B. Klingelhofer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1872

8. AGE: Years 74 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Chemists Ret.

11. Industry or business

FATHER 12. Name Carl W. Klingelhofer

13. Birthplace Germany

MOTHER 14. Maiden Name Christina Hock

15. Birthplace Germany

16 (a) Informant Mrs. Alice B. Klingelhofer

(b) Address 4203 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md

18 (a) Funeral director Geo. L. Berger Jr

(b) Address 1512 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

SEP 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1946 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 - 1946 to Sept 12 1946 and that I last saw him alive on Sept 12 1946.

Immediate cause of death Cardiac failure — Duration

Due to Cardio-Vasc-renal disease + Arteriosclerosis

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maynard Agnew

Address Maryland Gen. Hosp. Date signed 9-12-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Accession No. G43763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 567

G43763 Registered No.

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Walker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-14-26

8. AGE: Years	Months	Days	If less than one day
20	-	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Walker
13. Birthplace Virginia

MOTHER
14. Maiden Name Viola Campbell
15. Birthplace Virginia

16 (a) Informant Home
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-17-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co.
18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Edmondson Hill Ave
19 (a) (Date rec'd by registrar) (b) Transit Burial Permit

SEP 16 1946

V9-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1946, at 6 3-5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1946, to 9-12 1946, and that I last saw h alive on 9-12 1946.

Immediate cause of death Subarachnoid hemorrhage — Duration

Due to Cerebellar hemangioma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Wagley M. D.
Address Johns Hopkins Hosp Date signed 9-13-46

For Dr. J. Lukomski by Howard A. Mossman M.D.

G43764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 E

G43764 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5258 Nelson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City, (If outside city or town limits, write RURAL and give town)
(d) Street No. 5258 Nelson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bettie M. Bagent,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John T. Bagent,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1882

8. AGE: Years	Months	Days	If less than one day
63	8	15	hr. min.

9. Birthplace c Loudon County, Va. (Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business At home

FATHER
12. Name Daniel L. Bagent,
13. Birthplace Loudon County, Va.

MOTHER
14. Maiden Name Bettie Edwards,
15. Birthplace Loudon County, Va.

16 (a) Informant Mrs. Howard Bryan,
(b) Address 5258 Nelson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/46 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Cemetery,
Location Loudon County, Virginia

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date received by Registrar) Sep 16 1946 Registrar Huntington Hollinsead M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1946, at 2 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 9/15/46 and that I last saw her alive on 9/12 1946.

Immediate cause of death Endocarditis.

Duration 1 yrs.

Due to

Due to

Other Conditions Cancer.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H L de Bohm M. D.
Address 4723 Park Heights Date signed 9/15/46

X

G43765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

G43765 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Dolphin Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRISON FAUNTLEROY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Washington D C
(Town, county, and state)
10. Usual Occupation
11. Industry or business Labor.

FATHER
12. Name Preston Fauntleroy
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Fields
15. Birthplace Va.

16 (a) Informant Harry Davis
(b) Address 1213 Harlem Ave
17 (a) Burial, cremation, or removal (b) Date thereof Sept 15th 46
(month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Mt Winans
18 (a) Funeral director Ebey O W Ilson
(b) Address 1000 Bryant Ave
19 (a) (Date rec'd by registrar) (b)
Permit No. 10 1946 Hunting to Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946, at 5.30 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of chest involving heart and aorta.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-46, apprx. 5 a.m.
(b) Where did injury occur? 2002- Druid Hill Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearm

23. Signature Howard A. Werner M.D.
Medical Examiner.
Date signed 9-12-46

X

G43766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G43766
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 S.Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 S.Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M.Leader

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Stella M.Clapson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.3,1898

8. AGE: Years	Months	Days	If less than one day
47	10	9	hr. min.

9. Birthplace Steelton Pa.
(Town, county, and state)
10. Usual Occupation Stillman
11. Industry or business Paul Jones Dist.

FATHER
12. Name George E.
13. Birthplace Steelton Pa.

MOTHER
14. Maiden Name Edna B.Nunemaker
15. Birthplace Mt.Alto Pa.

16 (a) Informant Mother
(b) Address 1114 S.Robinson St.

17 (a) Burial (b) Date thereof Sept.16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

19 (a) SEP 16 1946 Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1946 at 3 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Sept 12 1946 and that I last saw h alive on Sept 12 1946.

Immediate cause of death Abdominal Hysterectomy C.V. Disease
Due to Cerebral Hemorrhage

Duration
1-5-46
9-9-46

Due to
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E.A.Schumacher M. D.
Address 8424 Eastern Ave Date signed 9-14-46

X

G43767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G43767 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM B. ANDERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Caroline E. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	24	hr. min.

9. Birthplace Princess Anne, Md.
(Town, county, and state)
10. Usual Occupation Carpenter, retired
11. Industry or business

FATHER
12. Name -- W. J. Anderson
13. Birthplace Princess Anne, Md.

MOTHER
14. Maiden Name Sarah H. Langford
15. Birthplace Princess Anne, Md.

16 (a) Informant Mrs. Caroline Anderson
(b) Address 2827 Walbrook Ave.

17 (a) Burial (b) Date thereof 9/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams M.D.
(Date received by registrar) (Signature of registrar)
SEP 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1944 to Sept 14 1946, and that I last saw him alive on Sept 12 1946

Immediate cause of death: Carcinoma of Stomach — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3432 Druid Park Ave (Date signed)

X

AB-92504 G43768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43768 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 8mos-6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Shaeffer

3 (b) If veteran, name war none

3 (c) Social Security Account No. 717-07-7345

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWED

6 (b) Name of husband or wife Agnes Shaeffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16- 1898

8. AGE: Years	Months	Days	If less than one day
47	9	28	hr. min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)
10. Usual Occupation Car inspector (retired)
11. Industry or business P. R. R.

FATHER
12. Name Andrew Shaeffer
13. Birthplace Maryland (Carroll Co., Md.)

MOTHER
14. Maiden Name Mary Evans
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial **(b) Date thereof** 9/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) SEP 16 1946 **(b)** Williams M.D.
(Date received by registrar) For Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1946, at 5.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1945 to 9-14 1946, and that I last saw h im alive on 9-14 1946.

Immediate cause of death Hypostatic Congestion
Cardiovascular Disease — Duration 15 y

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson M. D.
Address Balt. City Hospitals signed 9/19/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43769

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

G43769 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Dudley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Rudolf Perina

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Caroline E. Perina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1897

8. AGE: Years	Months	Days	If less than one day
48	10	4	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Mayor + City Council

FATHER
12. Name John Perina
13. Birthplace Austria Vienna

MOTHER
14. Maiden Name Frances m Nickel
15. Birthplace Austria, Vienna

16 (a) Informant Mrs. Caroline E. Perina
(b) Address 3309 Dudley Ave. 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17, 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 16 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1946, at 3 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Sept 14 1946 and that I last saw h. l. alive on Sept 10, 1946

Immediate cause of death: Pulmonary Embolism — Duration
Due to MYocardial Infarction
Due to Coronary Thrombosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen Lundell MD M. D.
Address 1211 Light St Date signed 9-14-46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G43770 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Copley Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Hartzell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Robert Hartzell

6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) 17 May 1870

8. AGE: Years	Months	Days	If less than one day
76	3	27	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Schultz
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Clara Schultz
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Emily Moeller
(b) Address 3407 Copley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. (a) SEP 16 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Sept 1946, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Aug 1946 to 14 Sept 1946, and that I last saw h alive on 14 Sept 1946

Immediate cause of death Carcinoma
Empyema Lung

Duration 2 mos ?

Due to

Due to

Other Conditions Pyloric Obstruction
Common duct obstruction

(Include pregnancy within 3 months of death)

Date of operation 14 Aug 46 and 11 Sept 46

Major findings of operation Carcinoma Pylorus
Fistula with common duct and pyloric obstruction

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

73. Signature W. P. Beal

Address Mercy Hosp. Date signed 14 Sept 46

X

G43771

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1634

G43771
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Sanner Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Joseph Siders

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No. 218-09-524

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace M. Siders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 12, 1907

8. AGE: Years: 39 | Months: 2 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Lamaine, Missouri
(Town, county, and state)

10. Usual Occupation: Machanic

11. Industry or business: Glenn L. Martin

FATHER
12. Name: Bert Siders
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Dema
15. Birthplace: Wisc.

16 (a) Informant: Mrs. Grace M. Siders
(b) Address: 4215 Sanner Ave. Balto. 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 16 '46 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15/46 1946 at 0:25 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Carbon Monoxide Poison

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/15/46 at A. M.
(b) Where did injury occur? 4215 Sanner Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Turned on gas burners

23. Signature: Thos. H. Edwards M.D.
Medical Examiner.
Date signed 9/16/46

G43772 BC# 54145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

G43772 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: South Balto. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 W. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Hawkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10. 1946

8. AGE: Years	Months	Days	If less than one day
	1	2	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Hawkins
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Annie Johnson
15. Birthplace Calvert County Maryland

16 (a) Informant Annie Hawkins
(b) Address 631 West Lee Street

17 (a) Burial (b) Date thereof Sept 16 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 66 North Bane Street

19 (a) SEP 16 1946 (b) Livingston Williams, M.D.
(Date Filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1946 at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Subinsky M.D.
Medical Examiner.
Date signed 9/13/46

VS 191

43773

G43773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Lexington St
(c) Hospital or institution:
aged Mariners + Widows Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N Lexington St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hill Todd

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1861

8. AGE: Years 85 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Ft Mechanicsville Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Nelson Todd
13. Birthplace Md

MOTHER 14. Maiden Name Anna Gregory
15. Birthplace Md

16 (a) Informant Aged Women's Home
(b) Address 1400 N Lexington St

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof 9/17/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Cook Jr
(b) Address 1314 Eutaw St

19 (a) 9-16-1946 (Date received by Registrar) (b) Clinton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1946, at 64 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4/ 1931 to 9/14/ 1946, and that I last saw him alive on 9 1946

Immediate cause of death: Sudden coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin B. Jarrell. M.D.
Address 11 E. Chase St., City Date signed 9/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43774 G43774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52 B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age; is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital gl
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** HARRY C. MAXWELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Lena A. Maxwell | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1896

8. AGE: Years	Months	Days	If less than one day
50	0	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation House Painter
11. Industry or business Self

FATHER
12. Name Charles Maxwell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna (Unknown)
15. Birthplace

16 (a) Informant Lena A. Maxwell (Wife)
(b) Address 2220 Mura St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/17/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

9CD 16 1946 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 September 1946 at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 July 1946, to 14 Sept 1946, and that I last saw him alive on 14 Sept 1946.

Immediate cause of death	Duration
Peritonitis	
Due to Perforated Hydronephrosis	
Due to Carcinoma of Pt "Bladder"	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10 Sept 46
Major findings of operation: Ca of Bladder
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Holland M. D.
Address Union Protestant Date signed 9/13/46

VS 150

643775

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 1937

Registered No. 643775

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward D. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Louise Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 23rd 1876

8. AGE: Years	Months	Days	If less than one day
70	5	21	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Building

FATHER
12. Name Henry Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Schisler
15. Birthplace Germany

16 (a) Informant John Wagner
(b) Address 10 E. Preston St.

17 (a) Burial (b) Date thereof 9/17/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Presbyterian
Location Govans

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 16 1946 (Date rec'd by reg'r) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1946, at 5 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1946 to Sept. 14 1946 and that I last saw him alive on Sept. 14 1946

Immediate cause of death: Acute myocardial failure — Duration

Due to arteria - sclerosis

Due to Possible Coronary thrombosis

Other Conditions Cystitis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. McCurdy M. D.
Address Univ. Hosp. Date signed 9/15/46

VS 150

X

3776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

G43776 Registered No.

Type or use ink. Spell out full the name of any city or county. Do not use abbreviations. In all cases answer every question. Where none, or not known, so state. Be sure that you also make entry in items 20 to 23 inclusive. Underline the causes of death clearly and legibly. Cause of death must be certified for every death. Indefinite or unsatisfactory causes of death will be returned for more complete information. Do not report deaths of stillborn children. Write plainly. Use permanent black ink. Do not write in margins. Do not fold. Physicians: please write the correct age in years, months, days, hours, or minutes, as the case may be. Do not leave any blanks. Your certificate is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1338 Andre Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 Andre Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JOHN TYSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Augusta V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1891

8. AGE: Years	Months	Days	If less than one day
55	5	12	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Ship Repairman
11. Industry or business U. S. Coast Guard

FATHER
12. Name Jpseph Tyson
13. Birthplace France

MOTHER
14. Maiden Name Margaret Davison
15. Birthplace Scotland

16 (a) Informant Mrs. Augusta V. Tyson
(b) Address 1338 Andre Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 16 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1946, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Sept 15 1946 and that I last saw h[illegible] alive on Sept 14 1946

Immediate cause of death: Ephacuation — Duration: 4 days
Due to: Pulmonary Embolism
Due to: V. F. B. Kidney Dodefun
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Campbell M. D.
Address 1644 Hanover Date signed Sept 16 1946

VS 150

G43777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 1927 G43777

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 N. Bruce St., 3 Ward)

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME William E. Dorsey 16

(a) Residence: No. 730 N. Bruce St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 1903

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Maryland

FATHER

13. NAME Samuel Dorsey

14. BIRTHPLACE (city or town) (State or country) St. Marys Co Maryland

MOTHER

15. MAIDEN NAME Lucy Waters

16. BIRTHPLACE (city or town) (State or country) St. Marys Co. Maryland

17. INFORMANT Annie Ward

(Address) 730 Bruce St

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Mt. Zion Cem. Date 9/18 1946

19. UNDERTAKER Metropolitan Funeral Home Inc.

(Address) 927 N. Mount St.

9/16 1946 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 15, 1946

22. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1946 to Sept 15, 1946

I last saw him alive on Sept 15, 1946 Death is said to have occurred on the date stated above, at 9a.m.

The principal cause of death and related causes of importance were as follows:

	Duration of onset
Valvular disease of heart with Coronary Sclerosis	12-2-35

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) John E. J. Compher X M.D.

(Address) 639 N. Carey St. Balto

G43778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G43778 Registered No.

Please write the causes of death clearly and legibly. Physicians: please state age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2546 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FALICE ALFINITO

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-29-1887

8. AGE: Years	Months	Days	If less than one day
59	2	15	hr. min.

9. Birthplace Naples, Italy
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Pasquale Alfinito
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Martini
15. Birthplace Italy

16 (a) Informant Miss Anna Citro
(b) Address 2546 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 9/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Signature of registrar Huntington Williams M.D.

SEP 16 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946, at 4:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 12 1946 and that I last saw him alive on Sept 11 1946.

Immediate cause of death	Duration
Coronary Embolism	
Due to following amputation of Thigh	
Due to Diabetes	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1729 W Lombard Date signed Sept 14 '46

G43779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G43779
Registered No.

Type or print the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Callaway Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Callaway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Ransom Johnston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Married

6 (b) Name of husband or wife M. Grace Johnston nee McLean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1875.

8. AGE: Years	Months	Days	If less than one day
71	4	20	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Coffee Broker
11. Industry or business

FATHER
12. Name John R. Johnston
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy Dellier
15. Birthplace N.C.

16 (a) Informant Mrs. M. Grace Johnston
(b) Address 3710 Callaway Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave.

19 (a) Filed (b) by registrar Florence Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1946 at 10 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946 to September 13 1946 and that I last saw alive on 9/13 1946.

Immediate cause of death Carcinoma Hepatobiliary — Duration 12 hours

Due to Arteriosclerosis (Duodenal) — 10 years

Due to

Other Conditions Chronic Bronchitis Cord Emphysema — 10 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Grafton Kerfoot
Address 214 Medical Arts Bldg Date signed 9/19/46

VS 150

43780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/93D

Registered No. G43780

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) None.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Prince Frederick
Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J. Frank Parran

3 (b) If veteran, name war: No

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife Mrs Margaret Parran

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1868

8. AGE: Years 78 | Months 7 | Days 27 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business —

FATHER
12. Name Thomas Parran
13. Birthplace Md.

MOTHER
14. Maiden Name Evelyn Sollee
15. Birthplace Md.

16 (a) Informant Wife
(b) Address — Prince Frederick, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Prince Frederick, Md

18 (a) Funeral director O. A. Harkness & Son
(b) Address Mutual, Md

19 (a) SEP 16 1946 (Date filed by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15, 1946, at 3:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29- 1946, to 9-15 1946 and that I last saw h[illegible] alive on 9-15 1946.

Immediate cause of death: Heart Failure — Duration: 20 days

Due to Arteriosclerotic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D'Antoni
Address Church Home & Hospital Signed 9/15/46

M. D.

VS 190

G43781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford La & Herring Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Lorman Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Joyce Elizabeth Windley
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 3, 1942

8. AGE: Years	Months	Days	If less than one day
4	4	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name James H. Windley
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Carrie Elizabeth Small
15. Birthplace N. Carolina

16 (a) Informant Aunt
(b) Address 1624 Lorman Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrose
Location Balto. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 N. Schroeder St.

19 (a) [illegible] (b) [illegible]
6 1946 (Filed by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1946, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946, to Sept 14 1946, and that I last saw her alive on Sept 14 1946.

Immediate cause of death	Duration
Tuberculous meningitis	16 days
Due to	
Due to	
Other Conditions Pulmonary tuberculosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G43782

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G43782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 N. Stricker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 N. Stricker (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Cornelia Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James Curtis (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-1890

8. AGE: Years 55 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Branch Gwinsdell

13. Birthplace Virginia

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Elizabeth Woods

(b) Address 1226 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (month) 17 (day) 46 (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Geo. G. Kelson

(b) Address 1303 Pennsylvania Ave

(c) Place of burial or removal Huntington Williams, Md.

(Date received by local registrar) SEP 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13- 1946 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1946 to 9-13 1946. and that I last saw her alive on 9-13-1946

Immediate cause of death: Coronary thrombosis — Duration: 30 minutes

Due to myocarditis — 5 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John Geo. J. Camper M. D.

Address 639 N. Carey St Date signed 9-16-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43783 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G43783 Registered No.

Please write the cause of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 S. Macon St, Balt 24
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 S. Macon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy ZOVKO

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-46

8. AGE: Years	Months	Days	If less than one day
			3 hr. min.

9. Birthplace Franklin Sq Hosp. Balt, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph D. Zovko
13. Birthplace Bethlehem, Penn.

MOTHER
14. Maiden Name Doris Mullen
15. Birthplace Middletown, Md.

16 (a) Informant Doris Mullen
(b) Address 415 S. Macon St Balt 24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Kelly-Zeiler Co
(b) Address 405 N. Eutaw St

19 (Signature of local registrar) SEP 16 1946 (date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1946, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19

Immediate cause of death Premature

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Huntington Williams M.D.
Address Franklin Sq Hosp Date signed 9/16/46

G43784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G43784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 W 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Palmer.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow.

6 (b) Name of husband or wife Frank R. Palmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9, 1866

8. AGE: Years	Months	Days	If less than one day
79	10	7	hr. min.

9. Birthplace maryland.
(Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name James Keefer.
13. Birthplace maryland.

MOTHER
14. Maiden Name Theresa Brightfue
15. Birthplace maryland.

16 (a) Informant Mrs. Henry Tazmierski
(b) Address 707 W 33rd St.

17 (a) Burial (b) Date thereof Sept 16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) SEP 16 1946 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1946, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 22nd 1946 to Sept 15 1946 and that I last saw h[illegible] alive on Sept 15 1946.

Immediate cause of death	Duration
Right Cerebral Thrombosis	10 days
Due to Cardio Renal Sclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature J H Pilcare M. D.
Address 617 W. 40th St. Date signed 9/16/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Pratt G43785

Larceny # 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G43785 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 700 Fleet Street 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
? 35			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 17 1946 (Date rec'd by registrar) Harrington Phillips M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26, 1946 at 3:35 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-46 at 4/ ? M.
(b) Where did injury occur? Found in the harbor
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Found floating - Pier 6 - Pratt St

23. Signature Howard J. Madden M.D. (Medical Examiner.)
Date signed 8/26/46

G43786 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G43786

Please write the cause of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Sts
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7008 Alden Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Garrett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/46

8. AGE: Years	Months	Days	If less than one day
			hr. 30 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Kenneth Garrett
13. Birthplace Md

MOTHER 14. Maiden Name Elmira Jones
15. Birthplace Balto. Md.

16 (a) Informant Kenneth Garrett
(b) Address 7008 Alden Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Morty Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) Date received SEP 16 1946 (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 19 46, at 1:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 19 46 to 9/15 19 46, and that I last saw her alive on 9/15 19 46

Duration

Immediate cause of death: Prematurity (Five or six weeks premature)
Due to: Hydramnios
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation No operation
Major findings of operations:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua Hammond M. D.
Address 6418 Windsor Mill Rd Exp

X Baltimore 7 Md 15 1946

G43787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43787 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town White Hall R.F.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Nelson Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Fannie Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1866

8. AGE: Years	Months	Days	If less than one day
79	11	18	hr. min.

9. Birthplace Baltimore County (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Edwin Wilson

13. Birthplace Unknown

MOTHER 14. Maiden Name Sarah Palmer

15. Birthplace White Hall, R.F.D.

16 (a) Informant B. F. Wilson

(b) Address Forest Hill, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17-46 (month) (day) (year)

(c) Cemetery or crematory West Liberty

Location White Hall, R.F.D. Md.

18 (a) Funeral director Howard S. Hopkins

(b) Address White Hall, Md.

SEP 16 1946 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1946, at 11.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1946, to Sept 15 1946, and that I last saw him alive on Sept. 15 1946.

	Duration
Immediate cause of death: Broncho Pneumonia.	4 days.
Due to: Generalized Arteriosclerosis	15 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norman R. Kleiman, M. D.

Address 3803 Edmondson Ave. Date signed Sept 16 1946

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58D

G43788
Registered No.

Please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Monument St
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. - 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Oswego Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Cohen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Louis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1905
8. AGE: Years 41 Months Days If less than one day hr. min.
9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Home Work
11. Industry or business

FATHER
12. Name Abrahgow
13. Birthplace Lith.

MOTHER
14. Maiden Name Rachael
15. Birthplace Lith.

16 (a) Informant Louis Cohen
(b) Address 2606 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-46 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd.
Location Windsor Mill Rd.

18 (a) Funeral director Jacob Levi Inc
(b) Address 1439 E. Balto St

19 (a) [illegible] (b) Signature of undertaker Washington Williams, Undertaker

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16-46 1946, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1946, to 9-16 1946, and that I last saw her alive on 9-16 1946.

Immediate cause of death Rheumatic Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Sinai Hosp. Date signed 9-16-46

VS 150

G43789 ✓ G43789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Abbott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Abbott St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Martinek

3 (b) If veteran, name war: Spanish Times | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1876

8. AGE: Years 70 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Joseph Martinek

13. Birthplace Bohemia

MOTHER 14. Maiden Name Rose

15. Birthplace Bohemia

16 (a) Informant Wm. J. Talbott

(b) Address 1114 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Frank Brachbar

(b) Address 900 N. Chester

19 (a) (Signature rec'd by registrar) (b) Registrar

SEP 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1946 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Sept 14 1946 and that I last saw h/m alive on Sept 13 1946

Immediate cause of death: Arteriosclerosis — Senile Related — Duration —

Due to Myocardial degeneration — Arteriosclerosis — Senile Related — 1 week

Due to Bronchitis — Senile Related — 1 week

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Klimek M. D.

Address 2623 E. Monument Date signed 9/16/46

47 X

HEALTH DEPARTMENT—CITY OF BALTIMORE

G43790 — CERTIFICATE OF DEATH — 48a — G43790

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 3234 Abell Ave St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mary A. Marien — If U. S. Veteran specify WAR

(a) Residence: No. 3234 Abell Ave St., Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Nov. 6, 1885

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Practical Nurse

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) March 1946

11. Total time (years) spent in this occupation 10 yrs

12. BIRTHPLACE (city or town) (State or country) Canada

FATHER

13. NAME Francois Marien

14. BIRTHPLACE (city or town) (State or country) Canada

MOTHER

15. MAIDEN NAME Emma Archambault

16. BIRTHPLACE (city or town) (State or country) Canada

17. INFORMANT Ernest Dawes (Address) 3234 Abell Ave

18. BURIAL, CREMATION OR REMOVAL Saint Joseph's Cem. Date Sept 19 1946

19. UNDERTAKER Fitchberg-Dawes Funeral Home Inc. (Address) 4644 Yorke Road

20. FILED SEP 16 1946 Registrar. Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 15, 1946

22. I HEREBY CERTIFY, That I attended deceased from Aug. 18 1946 to Sept 15 1946

I last saw h[illegible] alive on Sept 15 1946 Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Cervix Uteri	
Other contributory causes of importance: Metastatic Carcinoma of Liver	

Was an operation performed? Yes Date of April 1946

For what disease or injury? Carcinoma of Cervix

Name of operation

What test confirmed diagnosis Biopsy Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) Samuel B Wolfe M. D.

(Address) 1331 E North Ave

G43791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓G43791 Registered No. 45c

please write the causes of death clearly and legibly. Physicians: please state age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County
(c) City or town Algonac
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 St. Clair River Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Watts, Frederick Nelson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Vida M. Ihnken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	18	hr. min.

9. Birthplace ? Canada
(Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Edward E. Watts
13. Birthplace Canada

MOTHER
14. Maiden Name Mary Ann Dickinson
15. Birthplace Canada

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 9/16/46
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Algonac
Location Algonac Mich.

18 (a) Funeral director Ihnken Funeral Home
(b) Address 1217 Eastern Ave., Baltimore, Md.

SEP 16 1946
(Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1946, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1946, to Sept. 15 1946, and that I last saw him alive on Sept. 15 1946.

Immediate cause of death	Duration
Coronary sclerosis with occlusion	UNKNOWN
Due to Myocardial infarction	UNKNOWN
Due to	
Other Conditions Squamous cell carcinoma with metastasis to left cervical region (Significant conditions contributing to death but not related to immediate cause given above)	MORE THAN 1 YEAR

Date of operation (If performed within 3 months of death)
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles G. Spicknall
Charles G. Spicknall, Surgeon M. D.
Address US Marine Hospital, Baltimore, 11, Md. Date signed 9/16/46

G43792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43792 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County
(c) City or town Chicago
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 N. Lorell Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Revere, Frank Alexander

3 (b) If veteran, name war

3 (c) Social Security Account No. 348-20-9916

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1891

8. AGE: Years	Months	Days	If less than one day hr.	min.
55	8	5		

9. Birthplace Chicago, Ill.
(Town, county, and state)
10. Usual Occupation Chief Steward
11. Industry or business Seafarer

FATHER
12. Name Charles Revere
13. Birthplace Chicago, Ill.

MOTHER
14. Maiden Name Annie O'Keefe
15. Birthplace Chicago, Ill.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 9/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chicago
Location Chicago Ill.

18 (a) Funeral director Phillip McKay
(b) Address 1219 E. Fort Ave.

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar
SEP 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1946 at 4:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1946, to Sept. 15 1946, and that I last saw him alive on Sept. 15 1946.

	Duration
Immediate cause of death: Infarction of myocardium due to arterio-sclerotic heart disease	3 days
Due to: (2) Edema, pulmonary due to circulatory disturbance	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles G. Spicknall
Charles G. Spicknall, Surgeon M.D.
Address US Marine Hospital Date signed 9/16/46
Baltimore, 11, Md.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please

G43793 — BALTIMORE CITY HEALTH DEPARTMENT — G43793 Registered No.

CERTIFICATE OF DEATH

95c

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ mon.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Long Green (If outside city or town limits, write RURAL and give town)
(d) Street No. --- (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HENRY ECKHART

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ wife: Mary. M. Eckhart
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 24, 1867
8. AGE: Years 79 | Months 9 | Days 22 | If less than one day hr. min.
9. Birthplace Glyndon, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name William Eckhart
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Wesley
15. Birthplace Maryland

16 (a) Informant Mrs. Mary M. Eckhart
(b) Address Long Green, Balto. Co., Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory St. John's Luthern
Location Sweet Air, Balto. Co. Md.
18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland
SEP 16 1946 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1946, at 4:15 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Sept 15 1946, and that I last saw h~~im~~er alive on Sept 15 1946

Immediate cause of death	Duration
~~If~~ Cute Coronary Thrombosis	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Hullod, M.D.
Address 5 Gall. 3rd Hwy Date signed 9-15-46

VS 180

G43794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G43794 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth D. Russell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Howard H.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 29 1874
8. AGE: Years 72 Months 6 Days 13 If less than one day hr. min.
9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Housework
11. Industry or business
FATHER 12. Name Joseph Tyrrilion
13. Birthplace England.
MOTHER 14. Maiden Name Dont. Know
15. Birthplace
16 (a) Informant Mrs. Paul Lohr
(b) Address 3618 Reisterstown Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Sept. (day) 17 (year) 46
(c) Cemetery or crematory Parkwood
Location Taylor ave
18 (a) Funeral director John A. Hagan
(b) Address 3410 E. Balto. St
19 (a) Date received by registrar SEP 17 1946 (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1946, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 14 1946 and that I last saw h alive on Sept 14 1946

Immediate cause of death: Myocardial Infarction — Duration

Due to: Coronary Occlusion — 2

Due to: Hypertension

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible]
Address Abs. 2935 Date signed M. D. 9/16/46

VS 150

G43795 BC BALTIMORE CITY HEALTH DEPARTMENT ✓ G43795

File No. 104402 G-5577 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 940 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl McMillan (Daisy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9th 1946

8. AGE: Years | Months | Days | If less than one day 5 hr. 48 min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Frank McMillan; 13. Birthplace N. C

MOTHER — 14. Maiden Name Daisy Austin; 15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial, cremation, removal (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

19 (a) Date received by registrar SEP 17 1946 (b) Hunting ton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9th 1946, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946 to Sept 9 1946, and that I last saw her alive on Sept 9th 1946

Immediate cause of death: Bulbar Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address City Hospitals Date signed 13 Sept M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43796 — Reg. 104323 — DC# 655767 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 159 — Registered No. G43796

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26 T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) N.B

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Lehigh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Brown (Elsie

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	N. B

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6/1946

8. AGE: Years	Months	Days	If less than one day
			16 hr. ~~Days~~ min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Cliff Marvin
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsie Brown
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) ~~BURIAL~~ cremation ~~REMOVAL~~ (b) Date thereof 9/9/46 (month) (day) (year)
(c) ~~CEMETERY~~ crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

19 (a) SEP 17 94 (Date received by registrar) Huntington Wilkinson, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6/1946 19 at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 6 1946 to Sept 6 1946 and that I last saw h er alive on Sept 6/1946

Immediate cause of death	Duration
Pulmonary Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address City Hospitals Date signed 9/9/46 M. D.

VS 180

643797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 149a

Registered No. 643797

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Glen Arm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thelma M. Magill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Fredrick T. Magill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 27th 1919

8. AGE: Years: 26 | Months: 11 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Wm K. Byrne
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Ada M. Lancaster
15. Birthplace: Md.

16 (a) Informant: Mrs. Ada M. Byrne
(b) Address: 4305 Glen Arm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 Date received: SEP 17 1946 by Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1946, at 5 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1946, to Sept 16 1946, and that I last saw her alive on Sept 16 1946.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Atelectasis	
Due to: Post-operative Operation for Ruptured Pregnant Uterus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 15, 1946

Major findings of operation: Ruptured Uterus

of autopsy: Pyelonephritis, ureteral calculi

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Robert E. Farber, M.D.
Address: Bon Secours Hosp, Balto. Date signed: 9-16-46

VS 150

WILINSKI

G43798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G43798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 N Caroline St
(c) Hospital or institution: ST Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 3 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. East Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Doris C. Wilinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/9/30

8. AGE: Years 16 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Balto City (Town, county, and state) Md.

10. Usual Occupation STUDENT

11. Industry or business

FATHER 12. Name John Wilinski
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Marie W. Wirth
15. Birthplace Baltimore, Md.

16 (a) Informant Parents
(b) Address 518 N. East Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Signature of registrar) (b) Registrar

SEP 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1946 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1946 to 9/14 1946, and that I last saw h[illegible] alive on 9/14 1946

Immediate cause of death Uraemia — Duration

Due to Nephritis, subacute

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Subacute nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Leonardis
Address St Joseph Hospital Date signed 9/17/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43799

Colored # 11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G43799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Unknown
(a) State (b) County
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Christian ?

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
? 45			hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business ?

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant "
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 17 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1946, at 7:15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, ~~accident~~ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Found drowned

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at 3/2 ? M.
(b) Where did injury occur? Harbor foot of Bush St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury found drowned

23. Signature Howard J. Andrews M.D.
Medical Examiner.
Date signed 9-29-46

X X

3800 Grave # 10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G43800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Unknown
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60 !			hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 17 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 19 46 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found drowned

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at 22/1 ? M.
(b) Where did injury occur? Harlem-pier 6 Light St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury found drowned

23. Signature Howard J. Wilson M.D.
Medical Examiner.
Date signed 9-29-46

643801 BC# B 55458 BALTIMORE CITY HEALTH DEPARTMENT ✓ 643804

CERTIFICATE OF DEATH

159 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor
(c) Hospital or institution: W. Balto. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 50 E. Heath St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Reichert No 1
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1946
8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.
9. Birthplace Baltimore, MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Reichert
13. Birthplace Baltimore, MD.

MOTHER
14. Maiden Name Lillian West
15. Birthplace Balto MD.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 11 1946
18 (a) Funeral director Commissioner of Health
(b) Address
1946 SEP 17 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946 at 6:30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to Sept 4 1946
and that I last saw him alive on Sept 4 1946.

Immediate cause of death	Duration
Immediate cause of death: Respiratory failure	
Due to: Prematurity	
Due to: Sclerema	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph M. Smith M. D.
Address Date signed

VS 150

3802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G43802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital (Aon.)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Cheapside
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ivan Sentz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
48?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address
(c) SEP 17 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1946, at 8 1/2 A M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed Sept. 4, 1946

VS 151

G43803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G43803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Lanvale St. (Institutional location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Cuba

3 (a) FULL NAME Audra Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19. SEP 17 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Sept. 1946 at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kanmuth Jr. M.D.
Medical Examiner.
Date signed 2 Sept. 46

VS 151

343804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G43804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 852 Abbott Court
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 852 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida B. Hand

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John J. Hand
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1871

8. AGE: Years 75 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Chestnut Ridge Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at Home

FATHER
12. Name Henry Cole
13. Birthplace Baltimore, Co. Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. A. Tountsman
(b) Address 852 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location 3310 Gaylor Lane

18 (a) Funeral director Edward W. Conklin & Son
(b) Address 924 E. Eager St.

19 SEP 17 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1946, at 7:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3, 1946, to Sept 15 1946 and that I last saw her alive on Sept 14 1946.

	Duration
Immediate cause of death: Broncho-Pneumonia	5 days
Due to Cerebral Hemorrhage	13 mo
Due to Arterio-Sclerosis	25 years
Other Conditions Pyelo-nephritis and Cystitis	20 yrs

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James E. Peterman
Address 126 Hanover St. Date signed M. 9 D. 16 Y. 46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163C

G43805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Boyd Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21-1923

8. AGE: Years	Months	Days	If less than one day
22 23	11	23	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Herbert Wonqus
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Davis
15. Birthplace Md

16 (a) Informant Mr Boyd Morris
(b) Address 1514 Presstman St.

17 (a) Burial (b) Date thereof 9-18-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St

19 (a) SEP 17 1946 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1946, at 3.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said (Autopsy, Inspection or Inquiry) Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Lysol poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-14-46 approx. 3.30 p. M.
(b) Where did injury occur? 1514 Presstman St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Drank lysol

23. Signature George B. Magruder M.D.
Medical Examiner.
Date signed 9-16-46

G43806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G43806 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 Brooks Lane.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Brooks Lane. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA STERN KAHN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Moses Kahn.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1868.

8. AGE: Years 78 | Months 5 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joel Stern,
13. Birthplace Germany.

MOTHER
14. Maiden Name Fannie ?
15. Birthplace Germany.

16 (a) Informant Mr. Bernard Kahn,
(b) Address 937 Brooks Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim Son
(b) Address 1902 Eutaw Place.

19 (a) Sept 17 1946 Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15th. 1946 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946 to Sept 15 1946.
and that I last saw him alive on Sept 7 1946.
Immediate cause of death

Due to Arteriosclerotic Heart Disease
Coronary Sclerosis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 6 wks. 5 yrs. 3 yrs.

10 AM

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Irvin Pincoffs
Address Emersonian Apts. Date signed Sept 16/1946

G43807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G43807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 S. Kenwood ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 S. Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred J. Sloman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-4931

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Agnes H. Sloman
(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Machine operator
11. Industry or business

FATHER
12. Name Alfred Sloman
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Streckfuss
15. Birthplace Germany

16 (a) Informant Agnes H. Sloman
(b) Address 960 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)
(c) Cemetery or crematory Schwartz Cemetery
Location O'Donnell St

18 (a) Funeral director John F. Duda
(b) Address 2829 Hudson St.

19 (a) SEP 17 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16- 1946, at 6 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation due to hanging.

Due to

Other Conditions Neurosyphilis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/16/46 6 A. M.
(b) Where did injury occur? 900 S. Kenwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanged self.

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9-16-46

G43808 BC# F28023 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 36 — Registered No. G43808

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 294 Mason Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Rosmarie Rakowski

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 13 May 1941

8. AGE: Years	Months	Days	If less than one day
5	4	2	— hr. — min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Child
11. Industry or business "

FATHER
12. Name Frank Rakowski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Agnes Wisniewski
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 294 Mason Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County
18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street
19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

vs SEP 17 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Sept 1946, at 1A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 14 Sept 1946, to 15 Sept 1946, and that I last saw her alive on 15 Sept 1946

Immediate cause of death: Bulbar and Lagopha-litis Poliomyelitis — Duration: 6 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation T & A 2 weeks ago
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed

X

G43809 G43809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 McKean Ave (#17)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Catherine Grasser

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ---
6 (c) If alive, give age 188 yrs

7. Birth date of deceased (mo., day, yr.) Dec. 6, ~~1879~~

8. AGE: Years	Months	Days	If less than one day
65 ~~66~~	9	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At. Home
11. Industry or business

FATHER
12. Name Andrew Grasser
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Link
15. Birthplace Germany

16 (a) Informant Mrs. Catherine Buettner
(b) Address 5011 Holder Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16/46 19 —, at 5-45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Partial intest. obst.
Due to Adenocarcinoma of uterus.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 9/11/46
Major findings of operation: As above
of autopsy: As stated above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John F. Noguera MD
Address Md. Gen. Hosp. Date signed 9/16/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150 SEP 17 1946 Huntington Williams, M.D. (over)

G43810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43810 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 S. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 43YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 S. STRICKER St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME LENA O. TAAFE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOW

6 (b) Name of husband ~~or wife~~ JOHN G
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAR 15 1876

8. AGE: Years	Months	Days	If less than one day
70	6	7	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name L. SHIPLING
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16 (a) Informant MRS N. FOWLER
(b) Address 318 MARTINDALE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location EDMONDSON AVE

18 (a) Funeral director GEO. LEIMBACH
(b) Address 1211 LYNDHURST ST

19 (a) (Date rec'd by Registrar) (b) SEP 17 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 16 1946 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1946 to Sept. 15 1946 and that I last saw her alive on Sept. 15 1946.

Immediate cause of death BRONCHI PNEUMONIA — Duration

Due to

Due to

Other Conditions Arteriosclerosis C. V. D.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 3105 Frederick Ave. Date signed 9/16/46

VS 150

G43811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 920

Registered No. G43811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5206 Gwynn Oak Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5206 Gwynn Oak Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Whitney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1872

8. AGE: Years	Months	Days	If less than one day
74		4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Schoolteacher

FATHER
12. Name George H.Whitney Sr.
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Jane Harrison
15. Birthplace Ireland

16 (a) Informant F.Rose Whitney
(b) Address 5206 Gwynn Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry H. Armacost
(b) Address 4204 Ridgewood Ave

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 17 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1946, at 12 M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to 9-16 1946, and that I last saw h alive on 9-16 1946.

Immediate cause of death: Mitral Stenosis Cardiac Hypertrophy — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H H Queen M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G43812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4610 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4610 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah M. Breighner

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel S. Breighner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1869

8. AGE: Years	Months	Days	If less than one day
77	3	8	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Peter Groft.
13. Birthplace Penna.

MOTHER
14. Maiden Name McKinney,
15. Birthplace Penna.

16 (a) Informant Mrs. William J. Noonan, Sr.
(b) Address 4610 Park Heights Ave.

17 (a) Burial (b) Date thereof 9/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (b) Registrar
(Date received by registrar)

Verified SEP 17 1946

Courtesy of Maryland Historical Society

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1946 at 10 30P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1942 to 9/15 1946 and that I last saw her alive on 9/15 1946

Immediate cause of death Acute Cardiac dilitation 3rd

Due to Endocarditis.

Due to Myocarditis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration.
30 minutes
3yrs. 10 mos.
3yrs. 10 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. DeBarbieri M. D.
Address 4723 Park Heights Date signed 9/16/46

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G43813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43813 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 Cooks Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Cooks Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Virginia Meyer

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph H. Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1870

8. AGE: Years	Months	Days	If less than one day
76	5	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Albert Hisky,
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Kenny,
15. Birthplace Baltimore,

16 (a) Informant Miss Virginia Meyer,
(b) Address 610 Cooks Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City,

18 (a) Funeral director C. Vernon Kenmon
(b) Address 4611 Park Heights Ave.

19 (a) SEP 17 1946 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1946, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1945 to 9/13 1946, and that I last saw her alive on 9/12 1946

Immediate cause of death	Duration
Pulmonary Embolism	1 hr. 0
Due to Cardio-Vascular Disease	4
Due to	
Other Conditions Chronic Cholecystitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James H. Lazenberger M. D.
Address 524 Medical Arts Bldg. Date signed 9/14/46

Physician for Attending M.E.

G43814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G43814

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important. Use necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Oakland St.
(c) Hospital or institution West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 Moreland Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Rhasia

3 (a) FULL NAME Mrs. Katie Singer

3 (b) If veteran, name war

3 (c) Social Security account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ben Singer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bernard Gerber
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Ben Singer
(b) Address 1538 Moreland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-46 (month) (day) (year)
(c) Cemetery or crematory Dorsman Circle
Location Nr. Mt. Carmel

18 (a) Funeral director Jack Reuss & Co
(b) Address 1439 E. Balto St

17 (c) 1946 Filed by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1946 at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28, 1946 to Sept. 16, 1946 and that I last saw h[illegible] alive on Sept. 16, 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	
Due to	
Other Conditions Severe Parkinsonism	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Station Date signed 9/16/46

VS 190

G43815 95636 BC# BALTIMORE CITY HEALTH DEPARTMENT G43815
CERTIFICATE OF DEATH 159
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 23,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Stephen Guzick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1946

8. AGE: Years	Months	Days	If less than one day
			12 hr. 0 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Michael Guzick
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Jean Mary Cramblitt
15. Birthplace Baltimore Md.

16 (a) Informant John M Guzick
(b) Address 1845 W. Lombard St

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sept 19 1946
Location Ft. Mary Hampden Md

18 (a) Funeral director C. Wingfield & Son
(b) Address 501 E. 22nd St.

19 (a) Sept 17 1946 (b) Huntington Williams Hall
(Date received by local registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1946, at 9.45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1946, to Sept 16 1946, and that I last saw him alive on Sept 16 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Prematurity (36 weeks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber, M.D.
M. D.
Address Bons Secours Hosp. Date signed 9-16-46

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

G43816 Over

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 160a

G43816 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da
(e) Length of stay in Baltimore (yrs., mos., or days) 2da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balt Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Sollers pt. Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward Frazier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-46

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balt. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Charles H. Frazier
13. Birthplace Avon Co. Va

MOTHER
14. Maiden Name Josephine Schaefer
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director Tilly & Zeiler
(b) Address 1901 Eastern Ave

19 (a) 7 1946 (Date received by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946, at 9 A 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1946, to Sept 16 1946, and that I last saw he alive on Sept 16 1946.

Immediate cause of death	Duration
Petechial Intra-cranial hemorrhages	
Due to Intra Uterine Asphyxia	
Due to Premature Separation of Placenta	
Other Conditions 4 weeks premature	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Treptow
Address W. Balto Gen Hosp Date signed 9-17-46

X

Subject age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Conrad G43817

G43817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 N. Fremont ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N. Fremont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Conrad

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife John Conrad

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Wilmington Del.
(Town, county and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Earla Clements

(b) Address 904 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly ave

19 (a) Huntington Williams Mgr (Date received by registrar)

SEP 17 1946 VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Sept. 1946, at 8.35 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Rammer, M.D. Medical Examiner.
Date signed 15 Sept. 1946

X

G43818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 163H

G43818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp DOA - 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Providence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES H WALKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) August (27) 1894

8. AGE: Years 52 | Months - | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Walker
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Keller
15. Birthplace Md.

16 (a) Informant William J. Gosnell
(b) Address 151 Myrtle ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/17/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Brantley ave

19 (a) SEP 17 1946 (Date received by Registrar) **(b)** Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13/46 19__, at 5:45 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/13/46 at 4:00 P.M.
(b) Where did injury occur? 1005 Providence St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Gas burners on tent unlit

23. Signature John R Sears, M.D.
Medical Examiner.
Date signed 9/14/46

G43819

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 83a

G43819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1931

8. AGE: Years	Months	Days	If less than one day
15	3	14	hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)

10. Usual Occupation School Student

11. Industry or business

FATHER
12. Name Clarence Hill
13. Birthplace md

MOTHER
14. Maiden Name Virgie Jackson
15. Birthplace md.

16 (a) Informant [illegible]
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 20, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location Liberty, Hoy Woodard Road

18 (a) Funeral director D. B. Hoffler & Son
(b) Address New Windsor & Union Bridge Md

17 1946 (c) Livingston Williams M.D.
(Date rec'd by registrar) registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946 at 6.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-16 1946 to Sept-17 1946 and that I last saw him alive on Sept-17 1946.

Immediate cause of death: INTRACRANIAL VASCULAR ACCIDENT — Duration: 10hrs
Due to: Sickel Cell — 15yrs
Due to: Anemia
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas H. Caudill M. D.
Address Johns Hopkins Hosp Date signed 17 Sept 1946

Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 84a

G43820
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3da
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Cross St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Luther Bockelman

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 215-09-5594

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Elsie Bockelman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 8 1894

8. AGE: Years 51 Months 9 Days 7 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation TRUCK DRIVER

11. Industry or business

FATHER
12. Name JOHN H. BOCKELMANN
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name IDA TEMPLE
15. Birthplace BALTO. MD.

16 (a) Informant ELSIE BOCKELMANN
(b) Address 1223 W. CROSS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-18-46 (month) (day) (year)
(c) Cemetery or crematory LOUDEN PARK CEM.
Location FREDERICK AVE

18 (a) Funeral director Cushwa-Jones
(b) Address 414 N. Franklintown Rd.

19 (a) 9 17 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 19 46 at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 19 46 to 9-15 19 46 and that I last saw h/M alive on 9-15 19 46

Immediate cause of death: Pneumococcus Meningitis — Duration

Due to: Rt Suppurative Otitis Media

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Hector V. Schmidt M.D.
Address 1211 Light St. Date signed 9-15-46.

VS 150

Write the cause of death clearly and legibly. If age is especially important. Physicians: please write

G43821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43821
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Roslyn Heights- Long Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Church Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RALPH GARNER

3 (b) If veteran, name war: World war #1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-29-1893

8. AGE: Years 53 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Mississippi
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Garner
13. Birthplace Mississippi

MOTHER
14. Maiden Name Unknown
15. Birthplace Miss

16 (a) Informant Mamie Garner
(b) Address Roslyn Heights Long Island N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 18 46 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13. 1946 12.25 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Bruns M.D.
Medical Examiner.
Date signed 9/14/46

VS 191

G43822 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G43822 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Watkins & Caton Ave.
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 Dolan Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Byrne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 2 hrs. 5 min.

9. Birthplace Balto., Md.
(Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John A. Byrne

13. Birthplace

MOTHER 14. Maiden Name Helen Harman Byrne

15. Birthplace Md.

16 (a) Informant John A. Byrne
(b) Address 2419 Dorith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location

18 (a) Funeral director Edw. Forshaw
(b) Address 2013 Maryland Ave

19 (a) Sept 17 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1946 to 19 ; and that I last saw h[illegible] alive on 9/14 1946.

Immediate cause of death: Cardio Respiratory Failure
Due to: Prematurity

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hamilton Smith Jr. M.D.
M. D.
Address St Agnes Hosp Date signed 9/17/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G43823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Blvd near Dorsey (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Garnett W. Davis Jr

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife ✓
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 8th 1932
8. AGE: Years 14 Months 4 Days 23 If less than one day hr. min.
9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation School boy
11. Industry or business
FATHER 12. Name Garnett W. Davis
13. Birthplace Md.
MOTHER 14. Maiden Name Dorothy M. Layne
15. Birthplace Richmond Va.
16 (a) Informant Garnett W. Davis Sr.
(b) Address Washington Blvd. near Dorsey
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial Pk
Location Washington Blvd Dorsey Md
18 (a) Funeral director John J. Grayson & Son
(b) Address 900-03 Hollins St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar
SEP 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1946, at 3.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy, Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CUASE OF DEATH
Fractured Skull
Intracranial Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-46 at 3.30 p. M. Howard Co.
(b) Where did injury occur? Washington Blvd corner Baker's garage
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto struck bicycle on which he was riding

23. Signature Howard J. Sheldon M.D.
Medical Examiner.
Date signed 9-16-46

G43824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G43824 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Aves.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Barclay Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM WHITELEY (Wm. H. C. Whiteley)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	216-05-7266

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret E. Biggs
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) 9/4/1881

8. AGE: Years	Months	Days	If less than one day
65	0	12	######## min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Heating Engineer (Retired)
11. Industry or business

FATHER
12. Name George J. Whiteley
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Louise Mechalske
15. Birthplace Baltimore, Md.

16 (a) Informant Helen L. Whiteley (daughter)
(b) Address 1608 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hampden
Location 3900 Roland Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received) SEP 19 1946 (Registrar) Huntington Williams, M.D.

S.P. 1 1946
Pd. 1.50

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15, 1946 at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13, 1946 to Sept 15, 1946, and that I last saw him alive on Sept 15, 1946.

Immediate cause of death Uremia — Duration

Due to Gangrene, Right Leg — 2 days

Due to Diabetes Mellitus — 4 years

Other Conditions Arteriosclerotic Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature Albert Butvinik, M. D.
Address 3706 Rondale Road Date signed 9/16/46

Ohl Powell G43825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G43825 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 W Fayette
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1928 W Fayette (If rural give location)
(e) Citizen of foreign country? Not (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ellen Gladfelter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 1872

8. AGE: Years 74 | Months 6 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Owen E. Riley

13. Birthplace Va.

MOTHER 14. Maiden Name Anna Agnew

15. Birthplace Md

16 (a) Informant Mrs Ann H Duncan

(b) Address Jeffersonville Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-46 (Month) (Day) (Year)

(c) Cemetery or crematory Ft Meyer Cemetery

Location Baltimore Md

18 (a) Funeral director George A Fahey

(b) Address Fairbury & Fayette

19 (a) (Signature of registrar) Huntington Williams, M.D. Registrar

SEP 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1946, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Sept 15 1946 and that I last saw her alive on Sept. 15 1946

Immediate cause of death: Coronary Thrombosis

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J C Powell

Address 32 E Fredrick St Date signed 9/17/46 D.

X

G43826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G43826 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5601 Gwynn Oak Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5601 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William David Devese

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Lilly May Devese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1871

8. AGE: Years	Months	Days	If less than one day
75	3	1	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Cemetery

FATHER
12. Name Richard Thomas Devese
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name ? Sullivan
15. Birthplace Baltimore County, Md.

16 (a) Informant Mr. Howard Devese
(b) Address 5601 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) (b)
(Signature) Registrar

SEP 17 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1946 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1946 to Sept 15 1946 and that I last saw h in alive on Sept 15 1946.

Immediate cause of death Hypostatic
Pneumonia
Arteriosclerotic hypertens Dis, with Hypertrophy Congestive failure
Generalized arteriosclerosis
Duration 30 days

Other Conditions Simple prostatic hypertrophy and chronic asthma
(Include pregnancy within 3 months of death)

Date of operation Aug 15. 1946
Major findings of operation: prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Michel M.D.
Address 2901 Edmondson Ave Date signed Sept 16 1946 M. D.

X

G43827.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G43827 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4921 Windsor Mill Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4921 Windsor Mill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton Arthur Kirk

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Susan Iola Kirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1877

8. AGE: Years	Months	Days	If less than one day
69	6	20	hrs. min.

9. Birthplace Baltimore Co Md
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Frederick Kirk
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden name Mary Ellen Dunn
15. Birthplace Balto Co Md

16 (a) Informant Mrs. Susan Viola Kirk
(b) Address 4921 Windsor Mill Road

17 (a) Burial (b) Date thereof Sept. 19, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Gilbert & Aurora
(b) Address 4510 Liberty Heights Ave.

19 (a) SEP 17 1946 (b)
(Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1946 to Sept 17 1946 and that I last saw him alive on Sept 16 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 6 days
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4509 Liberty Hgts Ave Date signed

G43828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46E

G43828 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7309 Liberty Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Klohr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry J. Klohr
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) January 8, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	7	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Henry Kalb
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mary E. Weidemeyer
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Agnes D. Coulson
(b) Address 7309 Liberty Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Reisterstown, Md.
18 (a) Funeral director Wells Lamborn
(b) Address 4510 Liberty Heights Ave.
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 SEP 17 1946

MEDICAL CERTIFICATION 45

20. DATE OF DEATH 9/15 1946, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1946 to 9/15 1946 and that I last saw her alive on 9/15 1946

Immediate cause of death Embolus, Pulmonary — Duration 5 min.
Due to Venous Thrombosis, Pelvis — Duration Unknown 1-11 days
Due to Resection Colon — Duration 11 days
Other Conditions Adeno Carcinoma Cecum & Appendix
(Include pregnancy within 3 months of death)
Date of operation 9/4/45
Major findings of operation: Adeno Carcinoma Cecum & Appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Catherine W. Lyons M. D.
Address Bon Secours Hosp Date signed 9/15/46

X

G43829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G43829 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2654 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CONRAD T. WITTMAN

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 218-10-4633

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: ANNIE M.
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 27-Jan. 1894

8. AGE: Years 52 | Months 7 8 | Days 18 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER 12. Name Christian Wittman
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Elizabeth Fisher
MOTHER 15. Birthplace Maryland

16 (a) Informant Mrs. Annie M. Wittman
(b) Address 2654 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 18 Sept. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director E. B. Stiffert & Son
(b) Address 1800 Eutaw Place

19 (a) (Signature of local registrar) (b) Registrar

SEP 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1946, at 7:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Intracranial hemorrhage (subdural)
Alcoholism
Due to
Other Conditions: Cirrhosis of liver
Bronchopneumonia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/16/46

vs 81 Huntington Williams M.E.

643830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ X 83a

G43830
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Forest Glen Drive, Pasadena (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Sheetenhelm
3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?
4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Anna Elizabeth
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/27/1887
8. AGE: Years 58 Months 8 Days 20 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Salesman for
11. Industry or business Standard Supply & Tool

FATHER
12. Name J. E. Sheetenhelm
13. Birthplace ? Md.

MOTHER
14. Maiden Name Ella Starr
15. Birthplace ? Md

16 (a) Informant Mrs. Anna E. Sheetenhelm
(b) Address Forest Glen, Pasadena
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.
19 (a) (Date) (b) (Signature) Registrar

SEP 17 1946
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1946 at 11 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1946 to 9/16 1946 and that I last saw him alive on 9/16 1946

Immediate cause of death	Duration
Coronary thrombosis	4 days
hemorrhage	
Due to Generalized arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Herbert F. Sheeler, M.D.
Address St. Agnes Hosp. Date signed 9/17/46

VS 150

X

G43831

AB-83866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G43831 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs- 11mos- 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 27yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Said Belilakee- - or - Said Bilalakis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15- 1887

8. AGE: Years	Months	Days	If less than one day
59	0	21	hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hashem or Mejhum Bilalakis or Balilakee

13. Birthplace Greece

MOTHER 14. Maiden Name Macibe ?

15. Birthplace Greece

16 (a) Informant Baltimore City Hospitals Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 17 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 17 1946 Huntington Williams MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6- 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17- 1945 to 9-6- 1946 and that I last saw him alive on 9-6- 1946.

Immediate cause of death Bronchogenic Carcinoma of Lung — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Fasbender M. D.

Address Balto City Hosps Date signed 9-6-46

VS 150

correct age is especially important. Physicians please write the causes of death clearly and legibly.

G43832 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V159

G43832 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balt. Genl. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/46

8. AGE: Years | Months | Days | If less than one day 2 hr. min.

9. Birthplace West Balt. Genl. Hosp
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Smith
13. Birthplace Covington, Va.

MOTHER
14. Maiden Name Mary F. Billingsley
15. Birthplace Pa.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 17 1946

18 (a) Funeral director Commissioner of Health
(b) Address
SEP 17 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1946 19 , at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 19 46 to Sept 16 1946, and that I last saw her alive on Sept 16 19 46.

Immediate cause of death Atelectasis

Due to Prematurity

Due to

Other Conditions Pre-eclampsia Severe.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph M. Smith M. D.
Address West Baltimore Gen. Hosp Date signed 9-16-46

VS 150

correct age is especially important. Physicians: please write

G43833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G43833 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Laverne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sinkenbring (WILLIAM RICHARD SINKENBRING)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-01-3666

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret K Weber

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 21-1885

8. AGE: Years 61 Months 4 Days 15 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clothing Cutter

11. Industry or business

FATHER
12. Name William Sinkenbring
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia
15. Birthplace Germany

16 (a) Informant Mrs Margaret K Sinkenbring
(b) Address 116 Laverne Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Sept. 17, 46 (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Baltimore Md.

18 (a) Funeral director HENRY SAUER & SONS. INC.
(b) Address North Ave. & Broadway.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1946, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1946 to 9-14 1946, and that I last saw him alive on 9-14 1946

Immediate cause of death: Pulmonary embolism

Due to P.O. Fatty Adeno-Carcinoma of Colon (4½)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-11-46

Major findings of operation: Adeno Carcinoma Colon

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred Harrison M. D.
Address St Agnes Hosp Date signed 9-17-46

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43834 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G43834 Registered No.

Type or print clearly in ink. Do not write over dotted lines. Underline the correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light. Stud
(c) Hospital or institution: South Balto. G.N 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Grayson St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl [B] Langley (twin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/46

8. AGE: Years	Months	Days	If less than one day
			14 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Henry Langley
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Charlotte Anna Dietz
15. Birthplace Baltimore Md

16 (a) Informant Charlotte Langley
(b) Address 3203 Grayson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Marie Cook Lyfer.
(b) Address 1600 W 20th St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

SEP 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1946. to 9/17 1946. and that I last saw her alive on 9/17 19 46.

Immediate cause of death: Hemorrhage Due to Premature Birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Cohen

Address Sorb Balt. Gen Hosp Date signed 9/17 D. 46

X

AB-102007 G43835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43835 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Pace St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos-3days
(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs

3 (a) FULL NAME Samuel Portera

3 (b) If veteran, name war None
3 (c) Social Security Account No. 214-26-8636

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22- 1900

8. AGE: Years	Months	Days	If less than one day
46	1	23	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Produce Clerk
11. Industry or business Retired

FATHER 12. Name Anthony Portera
13. Birthplace Italy

MOTHER 14. Maiden Name Sarah Hughes
15. Birthplace Itely

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 Sep 17 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15- 1946, at 4.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12- 1946 to 9-15 1946, and that I last saw h im alive on 9-15- 1946

Immediate cause of death: Pulmonary tuberculosis, far advanced — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey E. Jordan, M.D.
Address Balto City Hosp. Date signed 9/17/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43836
Registered No.

Write the cause of death clearly and legibly. Physicians: please write with care. Street age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Gainesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Atwater, Ralph Edward

3 (b) If veteran, name war

3 (c) Social Security Account No. 263-09-8567

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Viola Lott Atwater
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 8, 1905

8. AGE: Years	Months	Days	If less than one day
41	2	8	hr. min.

9. Birthplace High Springs, Fla. (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Seafarer

FATHER
12. Name Frank Atwater
13. Birthplace Florida

MOTHER
14. Maiden Name Margaret Rives
15. Birthplace SC

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-46 (month) (day) (year)
(c) Cemetery or crematory High Springs
Location Zoyola

18 (a) Funeral director Robert Brooks Sons
(b) Address Hollins & Calhoun St

SEP 17 1946 (b) Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1946 at 12:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1946 to Sept. 16 1946. and that I last saw h im alive on Sept. 16 1946.

Immediate cause of death Pneumonia, terminal — Duration 5 days

Due to (2) Chronic glomerulo-nephritis — 9 mos.

Due to

Other Conditions Uremia — 2 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 9/17/46

VS 180

G43837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G43837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 Dolton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Dolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary McLeine Halsey

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 1874

8. AGE: Years 72 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Adelbert McLean
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant George M Halsey
(b) Address 526 W University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilson Conway
(b) Address 1 Court Sq

SEP 18 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Sept 17 1946 and that I last saw her alive on Sept 14 1946

Immediate cause of death: Coronary Thrombosis — Duration 1 hr

Due to Arteriosclerosis — Duration Several yrs

Due to Hypertension — Duration —

Due to Arteritis Mellitus — Duration —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H Grady M.D.
Address 1403 Park Ave Date signed 9/13/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G43838

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5840 Bellona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5840 Bellona Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F Chalk

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 30 1865
8. AGE: Years 80 | Months 8 | Days 17 | If less than one day hr. min.
9. Birthplace Baltimore MD (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James A Chalk
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sophia Beck
15. Birthplace Germany

16 (a) Informant Lilton Thurman
(b) Address 3105 Guilford Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery or crematory Druid Hill
Location Druid Hill Baltimore MD
18 (a) Funeral director Milton Cox Son
(b) Address 1219 N Pont St
19 (a) SEP 18 1946 (Date received by registrar) (b) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946, at 1:59 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Sept 1946, to 17 Sept 1946, and that I last saw him alive on 17 Sept 1946.

Immediate cause of death Uremia — Duration 3 days
Arteriosclerosis
Cardio-vascular renal
Due to disease
Due to
Other Conditions Prostatic hypertrophy 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Floyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed 17 Sept 46

G43839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G43839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 Edoncroft Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 812 Edoncroft Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elinore C Joyce

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow.

6 (b) Name of husband or wife: Stubbs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1875

8. AGE: Years 71 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace Minn Minn (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Bartlett
13. Birthplace Maine

MOTHER
14. Maiden Name Julia Varney
15. Birthplace Maine

16 (a) Informant Jas L Joyce
(b) Address 812 Edoncroft Rd

17. Burial (a) Burial, cremation, or removal (b) Date thereof (month) (day) (year) 9/19/46

(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Tilburn & Son
(b) Address 1217 St Paul St

19 (a) SEP 18 1946 (Delivered by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946, at 8 17 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946, to Sept 17 1946, and that I last saw h er alive on Sept 17 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 hr

Due to Hypertension, Arterial 15 yrs

Due to

Other Conditions Cardiac Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W Parsons M.D.
Address 1109 St Paul St Date signed 9-18-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

Registered No. G43840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Ramsay St. #23 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida V. Shoemaker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15. 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	9	2		83

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Shipley
13. Birthplace Md

MOTHER
14. Maiden Name Annie Shipley
15. Birthplace Md

16 (a) Informant Leroy Shoemaker
(b) Address 2224 Ramsay St. #23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Milburn Lee & Co
(b) Address 1217 E Fayette St

19 (a) SEP 18 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1946 at 12:29 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1946 to 9-17 1946, and that I last saw him alive on 9-17- 1946.

Immediate cause of death Hypostatic pneumonia — Duration
Due to pulmonary edema & atelectasis
Due to Cerebrovascular accident
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emily A Briggs, MD M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1184

G43841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dulaeland & Rayner Aves.
(c) Hospital or institution: West Baltimore General Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4123 Granada Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLIS BLUMENTHAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Simon Blumenthal
13. Birthplace Russia

MOTHER
14. Maiden Name Ida ?
15. Birthplace Russia

16 (a) Informant Henry Blumenthal
(b) Address 4123 Granada

17 (a) Burial (b) Date thereof Sept. 18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. Noth Ave.

19 (a) Date received by Registrar SEP 18 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17, 1946, at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 17, 1946 to Sept 17, 1946, and that I last saw him alive on Sept 17, 1946.

Immediate cause of death HEMETEMESIS — Duration 10 hrs.
Due to Unknown Etiology
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Rabinsky
Address 3706 Rosedale Rd. Date signed 9/19/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G43842 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen R. McCullough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: James B. McCullough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1856

8. AGE: Years 89 | Months 10 | Days 7 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Patient

11. Industry or business Nursing Home

FATHER
12. Name William Lamping
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca Ruckle
15. Birthplace Balto. Md.

16 (a) Informant Miss Emily Lamping
(b) Address 1800 St. Paul St.

17 (a) Burial (b) Date thereof 9/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 18 1946 Burlington Williams MD
(Signature and title)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16th 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1935 to Sept 16 1946 and that I last saw her alive on Sept 16 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Arterio-Sclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature D. Corbin Streett, M.D.
Address 712 Park Ave Balto 1 Md Date signed 16 Sept 1946

VS 150

G43843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G43843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12½ hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 550 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ann Glover

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace Marion, South Carolina (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Roosevelt
13. Birthplace South Carolina

MOTHER
14. Maiden Name ?
15. Birthplace South Carolina

16 (a) Informant Norris Glover
(b) Address 622 George Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery [redacted] Mt. Calvary.
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Avenue

19 (a) SEP 18 1946 (Date rec'd by registrar) (b) Huntington Ave Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1946 at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Cervical vertebrae
" pelvis
Due to Ruptured Urinary bladder
Other Conditions Pott's fracture.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-46 at 10:30 A.M.
(b) Where did injury occur? 550 Oxford St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from 3rd floor window accidentally to ground floor landing

23. Signature Howard J. Wadsworth M.D. Medical Examiner.
Date signed 9-16-46

VS 151

G43844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G43844

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3104 Presbury St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA E. SHREEVE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	Female	White	Married

6 (b) Name of husband or wife Charles C. Shreeve
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1871

8. AGE: Years	Months	Days	If less than one day
75	1	1	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrea Thomas
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Conley
15. Birthplace Va.

16 (a) Informant Mr. Charles C. Shreeve
(b) Address 3104 Presbury St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery or crematory Sandy Mount
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa. Aves.

19 (a) Filed SEP 18 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1946, at 1:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1st 1946 to Sept 16th 1946, and that I last saw him alive on Sept 14th 1946.

Immediate cause of death Hypertension
Cardio Vascular
Renal Disease

Duration
Unknown
Yrs

Due to

Due to

Other Conditions Coma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mr Paul Boyer M. D.
Address 410 Medical Arts Bldg Date signed Sept 17 1946

G43845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G43845 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5[illegible]
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba timore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 240 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN COOK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M.

6 (b) Name of husband or wife Anna D'Loom b5

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business ,

FATHER
12. Name
13. Birthplace ,

MOTHER
14. Maiden Name
15. Birthplace ,

16 (a) Informant Frank Court - Son
(b) Address [illegible] Rd.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-18-46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director J. L. McCauley
(b) Address 100 S. Fort Ave.

19 (a) (b)
(Date received by registrar)

SEP 18 1946 Washington Williams Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1946, at 12 p. M.

21. I certify that I took charge of the remains described above, held an inspec. & inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9/14/46

G43846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2045 Gough St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VINCENT JABLONSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-0598

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Jablonski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Jablonski
13. Birthplace Poland

MOTHER
14. Maiden Name Ludwika Zaleski
15. Birthplace Poland

16 (a) Informant Mary Jablonski
(b) Address 2045 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20 '46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozarzewski
(b) Address 1930 Eastern Ave Baltimore, Md.

19 (a) (Day actually received) (b) Registrar

SEP 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946, at 7 30 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary disease
Myocardial degeneration
Due to arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/17/46

G43847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G43847 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Cathedral Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 79 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Cathedral Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Louisa Katherine Reitz

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John A. Reitz
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1866

8. AGE: Years	Months	Days	If less than one day
79	9	21	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Frederick Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Schreiner
15. Birthplace Germany

16 (a) Informant Miss Katherine H. Reitz
(b) Address 704 Cathedral Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street

19 (a) ---------- (Date rec'd by registrar) (b) ---------- (Registrar)

VS SEP 18 1946

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 17th Sept. 1946, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3/46 19 to 9/17/46 19, and that I last saw h-- alive on 9/16/46 19

Immediate cause of death	Duration
Toxemia & Heart failure	
Due to Carcinoma of bladder with Multiple Metastases	6 mo.?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas A. Jones Jr. M. D.
Address 1025 N. Calvert St. Date signed 9/18/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G43848

Please write the cause of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Whitecat
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write Rural and name town)
(d) Street No. 920 Whitecat St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col	Married

6 (b) Name of husband or wife Minnie Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48	-	-	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Ford
13. Birthplace Calvert Co Md.

MOTHER
14. Maiden Name Lucinda Green
15. Birthplace Calvert Co. Md.

16 (a) Informant Joseph Ford
(b) Address 1168 - Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery or crematory Mts Creek
Location Calvert Co. Md

18 (a) Funeral director Metropolitan Funeral Home Inc
(b) Address 927 N. Mount St.

19 (a) SEP 18 1946 (Date received by registrar)
Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Sept 16 1946, and that I last saw h[e] alive on Sept 16 1946

Immediate cause of death
(a) Coronary Occlusion — Duration 5 hrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 754 Kenyon Date signed 9/18 1946

G43849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G43849
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE and JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 HUNTINGDON AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS MAMIE ETHEL DAWSON

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SEPARATED

6 (b) Name of husband or wife REFUSED

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 28 1890

8. AGE: Years	Months	Days	If less than one day
56	5	20	hr. min.

9. Birthplace VIRGINIA
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name WILLIAM DAWSON
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name LAURA SUTTON
15. Birthplace VIRGINIA

16 (a) Informant MRS FRED DAWSON
(b) Address 7 N. ROSEDALE ST.

17 (a) Buried (b) Date thereof 9-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md

18 (a) Funeral director L. J. Ruck
(b) Address 5365 Harford Rd

19 (a) SEP 18 1946 Clinton F. Williams, M.D.
(Signature and title)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 SEPT 1946, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1 JULY 1946, to 18 SEPT 1946, and that I last saw HER alive on 11 SEPT 1946.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to MYOCARDIAL INFARCTION	2 MONTHS
Due to ARTERIOSCLEROTIC HEART DISEASE	3 YRS
Other Conditions DIABETES MELLITUS	5 YRS

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred K B. Agee, Jr. M.D.
Address Women's Hospital Date signed 18 Sept

Fred K B. Agee, Jr. X

643850
JL - 104617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

643850
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1922

8. AGE: Years 23 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Helen King
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (c) SEP 18 1946
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1946, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1946 to Sept. 16 1946 and that I last saw her alive on Sept. 16 1946.

Immediate cause of death: Miliary tuberculosis, Glandular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marcy E. MacMullan M.D.
Address Balto City Hosp. Date signed 9/18/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43851 — 25-186850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G43851 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 E. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11-1880

8. AGE: Years	Months	Days	If less than one day
65	9	6	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19/46 (day) (year)
(c) Cemetery or crematory Mem. Gdns
Location Old Frederick Rd.

18 (a) Funeral director John. A. Mohan
(b) Address 300 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 18 1946

VS 160

MEDICAL CERTIFICATION AM

20. DATE OF DEATH September 17- 1946 at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11- 1946 to 9-17 1946 and that I last saw him alive on 9-17 1946

Immediate cause of death Bronchopneumonia & Congestive Ht. Failure. — Duration

Due to Arteriosclerotic & Hypertensive C-V Disease.

Due to

Other Conditions Chronic Bronchitis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto City Hosp Date signed 9-17-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G43852 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 E. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5
(e) Length of stay in Baltimore (yrs., mos., or days) 7 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charles Kohlmann

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joanna Kohlmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1869

8. AGE: Years 76 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Private detective

11. Industry or business

FATHER
12. Name Louis Kohlmann
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Schmidt
15. Birthplace Penza -

16 (a) Informant Mrs Joanna Kohlmann
(b) Address 2036 E. North Ave

17 (a) Burial (b) Date thereof 9/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (Signature and title of local registrar) SEP 18 1946 Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946, at 12:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946, to Sept 16, 1946, and that I last saw him alive on Sept 16, 1946.

	Duration
Immediate cause of death Bronchopneumonia	
Due to Arteriosclerosis	
Cardio Vascular disease	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Herzog M.D.
M. D.
Address 1927 E North Ave Date signed 9/17/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

93D

G43853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43853 Registered No. 122a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital 2 6 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 E Lombard St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Otto Thiele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1860

8. AGE: Years	Months	Days	If less than one day
86	1	5	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Wife carver

11. Industry or business

FATHER 12. Name Mr. Carl Thiele

13. Birthplace Germany

MOTHER 14. Maiden Name Teresa Paffe

15. Birthplace Germany

16 (a) Informant Attdg

(b) Address 3205 E Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18/46 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Welsh Funeral Home

(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 12a

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/46 19 to 9/15 1946 and that I last saw him alive on 9/15/46 19

Immediate cause of death	Duration
Heart failure	
Due to aspiration pneumonia & obstruction of trachea from cut	
Due to operation for strangulated hernia	
Other Conditions old age - poor nutrition	

(Include pregnancy within 3 months of death)

Date of operation 9/14/46

Major findings of operation: removal hernia & strangulated gut

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D Patterson M.D.

Address Church Home & Hosp. Date signed 9/20/46

PLEASE write the causes of death clearly and legibly. Physicians: please be especially important. Information required by statute. The

G43854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √ 83a

G43854 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lovataya
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2043 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME RAYMOND CLARK

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Emma Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 21 Nov. 1891

8. AGE: Years 54 | Months 10 | Days 4 | If less than one day hr. min. 26

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter
11. Industry or business Modern Bath

FATHER
12. Name William Clark
13. Birthplace Balto.

MOTHER
14. Maiden Name Delia Bitner
15. Birthplace Balto.

16 (a) Informant Margaret Clark
(b) Address 2043 Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20/46 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Balto Md

18 (a) Funeral director Wm. J. Funeral Home
(b) Address 2008 Orleans

19 (a) (Date received by registrar) (b) SEP 18 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept 1946, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Sept 1946, to 17 Sept 1946, and that I last saw h[illegible] alive on 17 Sept 1946.

Immediate cause of death Respiratory failure — Duration
Due to Subarachnoid Hem.
Due to Hypertension
Other Conditions Pyelonephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James O'Hare M. D.
Address Mercy Hosp. Date signed 9-17-46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G43855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 Brunswick St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Brunswick St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Fischer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1889

8. AGE: Years 57 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Steamfitter

11. Industry or business

FATHER
12. Name Ludwig A. Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha V. Muller
15. Birthplace Germany

16 (a) Informant Mrs. Nellie Flandorffer
(b) Address 520 Brunswick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore, Md.

18 (a) Funeral director Durward Q. Covington
(b) Address 21 W. 25th St.

19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar)

SEP 18 1946
VS No

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14th 1946 to Sept 15 1946. and that I last saw h[illegible] alive on Sept 15 1946

Immediate cause of death — Duration

Carcinoma of liver — ?
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Glassman M. D.
Address 26 P 7 Madison Av Date signed Sept 16 1946

X

G43856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1332- Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bunie H. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Flenora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1891

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace: Whitestone, Va. (Town, county, and state)

10. Usual Occupation: Housewife.

11. Industry or business

FATHER
12. Name: Robert W. Wright, Sr.
13. Birthplace: Va.

MOTHER
14. Maiden Name: Rosie Lee
15. Birthplace: Va.

16 (a) Informant: Robert W. Wright, Jr.
(b) Address: 1332 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/46 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Md

18 (a) Funeral director: Geo. S. Nelson
(b) Address: 1303 Pennsylvania Ave

19 (a) SEP 18 1946 (Date rec'd by registrar) Washington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1946, at 8 p. M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard S. Wessin M.D.
Medical Examiner.
Date signed 9/16/46

G43857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓185

Registered No. G43857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thorwald Hansen (Hansen)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Nellie Hansen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	9	hr. min.

9. Birthplace Norway
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Woodworker

FATHER
12. Name Unknown
13. Birthplace Norway

MOTHER
14. Maiden Name Karlson? Balke
15. Birthplace Norway

16 (a) Informant Nellie Hansen
(b) Address 7200 Ridge Blvd. Brooklyn N.Y.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Evergreen
Location Brooklyn, New York

18 (a) Funeral director Odd Fellows Funeral Home Inc.
(b) Address 4644 York Road 12.

19 (a) 9-18-1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17, 1946 at 1:15 a. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypostatic & acute dilatation of heart
Acute Congestion of lungs.
Due to Coronary Disease
Chronic Valvulitis - Mitral & Aortic

Other Conditions Arteriosclerosis
Congestion of all other viscera
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 9-8-46 at A. M.
(b) Where did injury occur? Belair Rd - 10 mi above the city limits.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? Yes
(d) Means of injury Cut finger on a hunting saw.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-17-46

G43858 BALTIMORE CITY HEALTH DEPARTMENT G43858

CERTIFICATE OF DEATH 4513

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 91 days
(e) Length of stay in Baltimore (yrs., mos., or days) 91 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 49-53 Mc Kay Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Gabrielsen, Gerhard Andrew

3 (b) If veteran, name war --

3 (c) Social Security Account No. 100-10-0435

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Hannah Thelin Gabrielsen
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1873

8. AGE: Years	Months	Days	If less than one day
72	9	11	hr. min.

9. Birthplace ? Norway (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Harvold Gabrielsen
13. Birthplace Norway

MOTHER
14. Maiden Name ? Leona Oleana
15. Birthplace Norway

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial-Removal (b) Date thereof 9/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Brooklyn, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

SEP 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1946, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1946 to Sept. 17 1946, and that I last saw him alive on Sept. 17 1946.

	Duration
Immediate cause of death Necrosis & hemorrhage from nasopharynx	UNKNOWN
(2) Lobar pneumonia, entire right lung	UNKNOWN
Due to Carcinoma of left side of tongue	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 9/18/46

PLEASE WRITE PLAINLY, with indelible pencil. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

Registered No. G43859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. POSTILL

3 (b) If veteran, name war	3 (c) Social Security Account No.		
None	None		
4. Sex	**5. Color or race**	**6 (a) Single, married, widowed, or divorced**	
Female	White	Widow	

6 (b) Name of husband or wife Charles J. Postill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1860

8. AGE: Years	Months	Days	If less than one day
86	8	4	hr. min.

9. Birthplace Nappa, California
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John B. Richmond
13. Birthplace England

MOTHER
14. Maiden Name Sarah J. Postill
15. Birthplace New York

16 (a) Informant Mrs. Nellie F. Doberer
(b) Address 2226 Walbrook Ave.

17 (a) Burial (b) Date thereof 9/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 18 1946

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 17, 1946, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1946 to Sept. 17 1946, and that I last saw h[illegible] alive on Sept. 17 1946

Immediate cause of death

Consequence of Stomach. — Duration

Due to Cancer of Stomach. — 4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2200 Garrison Blvd. Date signed 9/18/46

X

G43860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G43860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1553 N. Gilmore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1553 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mack Baskerville

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day hr.	min.
65				

9. Birthplace Macklinburg Va.
(Town, county and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Henry Baskerville
13. Birthplace Macklinburg Va.

MOTHER
14. Maiden Name Jenny Tolle
15. Birthplace Macklinburg Va.

16 (a) Informant Clarabell Fuller
(b) Address 1553 N. Gilmore St.

17 (a) Burial (b) Date thereof Sept. 18, 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.,

SEP 18 1937 (a) (b) Katie R. Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1937, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1937, to Sept 15 1937 and that I last saw him alive on Sept 2 1937.

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr
Due to Broken Compensation	4 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edelbert Frey M. D.
Address 1928 Penna Ave Date signed 9/18/37

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43861

AB-103641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1362

Registered No. G43861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos. 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Chesapside (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Friedrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26-1898

8. AGE: Years	Months	Days	If less than one day
48	6	19	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rudolph Friedrich
13. Birthplace Austria

MOTHER
14. Maiden Name Antonia Patko-or-Antonia Potka
15. Birthplace Austria

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 18 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15- 1946 at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10- 1946 to 9-15- 1946 and that I last saw him alive on 9-15 1946.

Immediate cause of death: Pulmonary tuberculosis, far advanced

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marcy E. McMillan M. D.
Address Balto City Hosp Date signed 9/17/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43862

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 131 B

Registered No. G43862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. ~~(yrs., mos., or days)~~ 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town Rural - Deale
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston Sherbert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1894

8. AGE: Years	Months	Days	If less than one day
52	6	21 20	hr. min.

9. Birthplace Deale, A.A. Co. Md.
(Town, county and state)
10. Usual Occupation Surface Laborer
11. Industry or business Refractory Co.

FATHER
12. Name George M. Sherbert
13. Birthplace A.A. Co. Md.

MOTHER
14. Maiden Name Emma Rogers
15. Birthplace A.A. Co. Md.

16 (a) Informant Louis M. Phipps
(b) Address College Ave. Annapolis Md.

17 (a) Burial (b) Date thereof (month) (day) 9 20 46 (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Sherbert Cemetery
Location Deale, A.A. Co. Md.

18 (a) Funeral director John M. Layton & Son
(b) Address Annapolis, Md.

19 (a) Thomas Jon Williams, M.D. Registrar
(Date received by registrar)

SEP 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946 to Sept 17 1946, and that I last saw him alive on Sept 17 1946

Immediate cause of death	Duration
Hypertensive C-V-R. Disease & Arteria Sclerosis	
Due to Chronic Glom Nephritis Uremia	
Due to Heart Failure. Pulmonary Edema & Atelectasis	
Other Conditions Terminal Pneumonia Hypertrophy of Heart.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R E Bauer M.D.
M. D.
Address University Hosp Date signed 9-17-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

643863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 137a

643863 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Lutherville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles G. Boyd

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Laura Odell Boyd
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1880

8. AGE: Years	Months	Days	If less than one day
66	1	13	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name James Boyd
13. Birthplace Pa.

MOTHER
14. Maiden Name Cecilia Stover
15. Birthplace Pa.

16 (a) Informant Laura V. Boyd
(b) Address Lutherville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)
(c) Cemetery or crematory Grace Reformed
Location Taneytown Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street, Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 19 1946

vs 154

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1946, to Sept 18 1946, and that I last saw him alive on Sept 17 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	2 days
Due to Possible Idiopathic Purpura	5 days
Due to Possible Pneumonia	
Other Conditions Prostatectomy Biopsy - prostate Cystotomy (Include pregnancy within 3 months of death)	

Date of operation 9-3-46 9-13-46
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams M. D.
Address Mercy Hospital Date signed 9-18-46

X

Please write in ink. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43864 — BALTIMORE CITY HEALTH DEPARTMENT — G43864 Registered No.

CERTIFICATE OF DEATH 49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 N. Charles St. Balto. 18
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Hoffmaster (CHARLOTTE F. HOFFMASTER)

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Frank Solomon Hoffmaster

6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) June 24 1863

8. AGE: Years 83 Months 2 Days 25 If less than one day hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Mr. Henry Focht
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: ? Bush
15. Birthplace: Pennsylvania

16 (a) Informant: Union Memorial Hosp Records
(b) Address: 33rd. + Calvert Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)
(c) Cemetery or crematory: Loraine
Location: Middletown Md

18 (a) Funeral director: Milton Lord Lee
(b) Address: 1219 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

SEP 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Sept. 18 1946, and that I last saw her alive on Sept. 18 1946.

Immediate cause of death: Generalized Carcinomatosis — Duration:

Due to: Carcinoma of ovaries, bilateral

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. K. Steele, M.D. M. D.

Address UMH Date signed 9/18/46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1246 B

G43865 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St
(c) Hospital or institution:
St Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne's
(c) City or town Stevensville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Frank C Thomas Jr.

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth May Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25th 1877

8. AGE: Years	Months	Days	If less than one day
68	11	23	hr. min.

9. Birthplace Stevensville Md.
(Town, county and state)

10. Usual Occupation Funeral Director

11. Industry or business Own Business

FATHER
12. Name Frank C. Thomas Sr.
13. Birthplace Stevensville Md.

MOTHER
14. Maiden Name Blessina Lewis
15. Birthplace Stevensville Md.

16 (a) Informant Alton Thomas
(b) Address 345 E. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)
(c) Cemetery or crematory Stevensville Md
Location

18 (a) Funeral director Fr Alton Thomas
(b) Address 345 E 28th Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1946 at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Sept 18 1946; and that I last saw him alive on Sept 18 1946.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cirhosis of Liver

Due to Arteris-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation not done
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Wirth
Address Hosp Date signed 9-18-46

Huntington Williams, M.D.

X

MB 150

SEP 19 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G43866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.C.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 S. Stricker Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie E. Miller
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 16, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Boiler Maker
11. Industry or business B&O. R.R.

FATHER
12. Name John G. Miller
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Denning
15. Birthplace England

16 (a) Informant Minnie E. Miller
(b) Address 304 S. Stricker St.

17 (a) Burial (b) Date thereof Sept 21- 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel-Son
(b) Address 801 W. Fayette St.

19 (a) Date received by registrar SEP 19 1946 (b) Signature Huntington Williams M.D.
Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946, at 11.40 P.M.

21. I certify that I took charge of the remains described above, held an inspec. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Diabetes Mellitus
Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 9/18/46

X

G43867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G43867 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 Annabel Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Annabel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph N. Mewshaw

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Viola S.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1891

8. AGE: Years	Months	Days	If less than one day
55	1	3	hr. min.

9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Gov't Employee
11. Industry or business Internal Revenue

FATHER
12. Name Enoch A. Mewshaw
13. Birthplace Maryland

MOTHER
14. Maiden Name Ashia D. Salark
15. Birthplace Maryland

16 (a) Informant Mrs Viola Mewshaw
(b) Address 527 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hall
Location Annapolis Blvd

18 (a) Funeral director John F Dunn & Son
(b) Address 767 Light St.

19 (a) Date received by local registrar SEP 19 1946 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1946 at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to Sept 16 1946 and that I last saw h.i.m. alive on Sept 14 1946.

Immediate cause of death Adeno-Carcinoma of Cervical glands — | Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Biopsy of Cervical glands
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Lubin M. D.
Address 720 Patapsco Ave Date signed 9/15/46

G43868
AB-101555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √46a

G43868
Registered No.

write the causes of death clearly and legibly. Physicians; please write plainly; where correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos- 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 46yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Barenpohl

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-12-6627

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5- 1870

8. AGE: Years 76 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Foretrack Brew.

FATHER 12. Name Herman Barenpohl

13. Birthplace Germany

MOTHER 14. Maiden name Gesina Schneider

15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Record

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29 1946 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore

18 (a) Funeral director Frederick A. Cole

(b) Address 1200 W. Lombard St.

19 (a) (Date rec'd by registrar) (b) Registrar

vs SEP 19 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17- 1946, at 1.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25- 1946 to 9-17 1946, and that I last saw him alive on 9-17 1946.

Immediate cause of death	Duration
Atelectasis Lower Lobes Both Lungs	2 days
Due to Vascular accident Rt. Cerebral Hemisphere	4 days
Due to Carcinoma of Esophagus	months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-2-46 & 9-13-46

Major findings of operation: Carcinoma of Esophagus with obstruction

Autopsy: Dr. Adams.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth E. Nutterville, M.D.

Address Balt. City Hosp. Date signed 9-18, 1946

2 Cert
G43869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G43869
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 N Bond St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N. Bond St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Samuel S. Cheese jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-2272

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1907

8. AGE: Years 37 | Months 2 | Days | If less than one day ..... hr. ..... min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Samuel S Cheese Sr

13. Birthplace S.C.

MOTHER 14. Maiden Name Susan ?

15. Birthplace S C

16 (a) Informant Anna Cheese

(b) Address 910 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 1946

(c) Cemetery or crematory Mon Amelia Location Jarrettsville Md

18 (a) Funeral director Robert Williams

(b) Address 1515 McElderry St

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

SEP 19 1946 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1946, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Sept 17 1946, and that I last saw h alive on Sept 17 1946.

Immediate cause of death Pulmonary Tuberculosis

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Helen L Refuse
Address 842 N. Bond Date signed 9/17/46

PLEASE WRITE LEGIBLY WITH PERMANENT INK. Sign and fill out certificate immediately upon receipt. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

27° G43870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1578

Registered No. G43870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Hendershott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	married

6 (b) Name of husband or wife Elizabeth Hendershott 6 If alive, give age 1 8 years

7. Birth date of deceased (mo., day, yr.) 8-25-26

8. AGE: Years	Months	Days	If less than one day
20	-	21	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Thomas Hendershott
13. Birthplace Penn.

MOTHER
14. Maiden Name Samella Gibson
15. Birthplace Tennessee

16 (a) Informant Nurse
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17 1946 (month) (day) (year)
(c) Cemetery or crematory Antietam Memorial Park Location Antietam Md

18 (a) Funeral director Robert E. Williams
(b) Address 15 15 McElderry St

19 (a) Filed SEP 20 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1946, at 5 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1946 to 9-15 1946 and that I last saw h alive on 9-16 1946.

Immediate cause of death HEART FAILURE — Duration 4 days

Due to Congenital Heart Disease — 20 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Douglas Carroll
Address Johns Hopkins Hosp. Date signed 9-16-46

DOUGLAS CARROLL

VS 150

G43871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 D

G43871 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Hillen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Goedberg

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1846

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Paul Goedberg
13. Birthplace Russia

MOTHER
14. Maiden Name Ethel ?
15. Birthplace Russia

16 (a) Informant Mrs. Rose Schneider
(b) Address 2520 Guilford Ave.

17 (a) Burial (b) Date thereof 9-19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) Date received by registrar SEP 19 1946 (b) Harrington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19-1946, at 5 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of rectum.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-19-46

G43872 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G43872

CERTIFICATE OF DEATH

937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen'l Hosp DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name of town)
(d) Street No. 2519 Bosworth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Roessler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Marjorie

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1891

8. AGE: Years	Months	Days	If less than one day
55	7	13	hr. min.

9. Birthplace Shrewsbury, Penna. (Town, county, and state)

10. Usual Occupation Hotel Properitor

11. Industry or business Self

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Donald Roessler, Jr.
(b) Address

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/20/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

SEP 19 1946 Washington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept 1946 at 11:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelbach M.D. (Medical Examiner)
Date signed 18 Sept 46

VS 151

G43873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G43873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 Gibbons Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Gibbons Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Battenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1887

8. AGE: Years	Months	Days	If less than one day
58	10	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business —

FATHER
12. Name William Battenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Sippel
15. Birthplace Germany

16 (a) Informant Ida Schellhase
(b) Address 3101 Gibbons Ave

17 (a) Burial (b) Date thereof 9/20/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or mausoleum~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook
(b) Address 1217 ~~St. Paul St.~~ Washington Boulevard

19 (a) (Date filed) (b) Registrar

SEP 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1946; 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to Sept 18 1946, and that I last saw deceased alive on Sept 17 1946.

Immediate cause of death: Carcinoma Gall Bladder and Colon — Duration 2 Yrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation June 1946

Major findings of operation: Carcinoma Gall Bladder and Colon

Autopsy? No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Gordy M. D.
Address 5706 Harford Rd Date signed 9/19/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G43874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 590 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 590 Baker St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wm. H. Henderson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-80

8. AGE: Years 61 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Laborer
11. Industry or business Contractor

FATHER
12. Name Eggie Henderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Julia J.
15. Birthplace Maryland

16 (a) Informant Lillie Mae Henderson
(b) Address 590 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md
18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St.
19 (a) Date received by registrar Sept 19 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17- 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10- 1946 to 9-17 1946, and that I last saw h alive on 9-17- 1946.

Immediate cause of death: Chronic Valvular Heart Disease — Duration 4 mos.
Due to
Due to
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C Page
Address 1816 N. Mount St (17) Date signed 9-19-46

VS 190

Females: Write maiden surname. Males: Write surname. Give full name of deceased. Do not use initials. Do not abbreviate. Write plainly with pen and ink. Use black ink. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

~~43872~~ ~~390739~~ 391556 BALTIMORE CITY HEALTH DEPARTMENT G43875

CERTIFICATE OF DEATH 96 ✓

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltima
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Black	Married —

6 (b) Name of husband or wife Bessie Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~7-11-48~~ 5/12/69

8. AGE: Years	Months	Days	If less than one day
77	4	6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Martha ?
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pressman St
SEP 19 1946 Huntington Williams Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946, at 6 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from September 6 1946, to Sept. 18 1946, and that I last saw him alive on Sept. 18 1946.

Immediate cause of death	Duration
UREMIA, CIRCULATORY COLLARSE	
Due to Bladder obstruction	
Due to Left iliac aneurysm	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept. 13, 1946
Major findings of operation Left iliac aneurysm
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bruce J. Tracy M. D.
Address Johns Hopkins Hosp Date signed 9-18-46

VS 150

PERSONS WHO FURNISH FALSE OR INCOMPLETE INFORMATION ARE LIABLE TO PENALTY. Supply the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

43876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43876 Registered No.

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Give the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Scott Street
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Scott Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Noble Lee Rider

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1881

8. AGE: Years	Months	Days	If less than one day
65	7	7 6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Engineer Inspector
11. Industry or business City of Baltimore

FATHER
12. Name William N. Rider
13. Birthplace Maryland

MOTHER
14. Maiden Name Betty Schaeffer
15. Birthplace Maryland

16 (a) Informant Mrs. Noble Lee Rider
(b) Address 415 Scott Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/46 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Westminster, Md.

18 (a) Funeral director H. W. Meredon
(b) Address 805 N. Calvert Street

SEP 19 1946 (a) Date received by registrar (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945 to Sept. 17, 1946 and that I last saw him alive on Sept. 17, 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days

Due to: Hypertensive Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Kemp
Address 3030 Edmondson Ave. Date signed 9/19/46 (M D)

X

To be approved by medical examiner

G4387.7 G02027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G4387.7 Registered No. 120a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene St.
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 536 Addison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME June Lee Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1944

8. AGE: Years	Months	Days	If less than one day
2	3	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Noah Henson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Aldora Jefferson
15. Birthplace Ga.

16 (a) Informant Aldora Jefferson
(b) Address 536 Addison St

17 (a) Burial (b) Date thereof Sept. 20 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Wm. Katie R. Pellegrini
(b) Address 3229 W. Lehrorder St.

19 (a) 1946 Huntington Williams M.D.
(Filed by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1946, at 3:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1946, to 2:45 & 3:50 a.m. P.M. and that I last saw h[illegible] alive on Sept 16 1946.

Immediate cause of death	Duration
Dehydration and acidosis	
Due to a Nausea + vomiting diarrhea	
Due to Gastroenteritis	
Other Conditions Spastic diplegia and mental retardation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M. D.
Address University Hosp. Date signed 9-16-46
Redwood + Greene Sts.

Thomas J. Anderson, M. D. X

VS 150

PRESS WHITE CARBON WITH ONE ADDING PIN. Entries must be typewritten or printed in ink. Do not write over printing. Be careful to report all the causes of death clearly and legibly. Cause of death is especially important. Physicians: please write the cause of death clearly and legibly.

G43878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G43878 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital. 4 - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 N. Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Georgiana Baily
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1901

8. AGE: Years	Months	Days	If less than one day
44	11	8	hr. min.

9. Birthplace Hertford N.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Baily
13. Birthplace Hertford, N.C.

MOTHER
14. Maiden Name Maggie Spellman
15. Birthplace Hertford N.C.

16 (a) Informant Georgiana Bailey
(b) Address 102 E. Strikes Alley

17 (a) Burial (b) Date thereof Sept 20, 1946
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) 1946 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1946, at 5.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage due to bullet wound of neck involving sub-clavian vessels + lung

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-46 at approx. 5. P. M.
(b) Where did injury occur? 230 N. Pearl St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm
23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 9-16-46

G43879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G43879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 E. Preston St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Myers

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Geo. F. Myers
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 17 1895
8. AGE: Years 37 | Months 0 | Days 17 | If less than one day: hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Patrick P. Reynolds
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Conroy
15. Birthplace England

16 (a) Informant Mrs. George F. Myers
(b) Address 707 E. Preston St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cem. Co.
Location 4300 Old Frederick Rd.
18 (a) Funeral director Edward W. Conklin Son
(b) Address 924 E. Lanvale St.
19 (a) Filed SEP 19 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18, 1946, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 47 to Sept 18 1946, and that I last saw her alive on Sept 17 1946.

	Duration
Immediate cause of death: Secondary Carcinoma of liver	2
Due to: Primary Carcinoma of rectum	?
Due to:	
Other Conditions: Cystadenoma Thyroid. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverstein M. D.
Address 514 E. Lexington Date signed Sept 18 1946

X

G43880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 61

Registered No. G43880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison and Linden
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town Royal Oak
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Kathleen Leonard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem.	White	Widowed

6 (b) Name of husband or wife Henry T. Leonard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12 1897

8. AGE: Years	Months	Days	If less than one day
48	11	5	Hr. — min.

9. Birthplace Centreville Md
(Town, county, and state)

10. Usual Occupation H. W.
11. Industry or business Home

FATHER
12. Name John F. Corbett
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Frances Stokes
15. Birthplace Centreville Md

16 (a) Informant Mrs. H. Taylor Lankford
(b) Address 1901 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)

(c) Cemetery or crematory
Location St. Michaels Md

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (b)
(Signature and title or relation)

SEP 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept. 1946, at 9 37 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Sept.~~ 25 1946, to 17 Sept. 1946 and that I last saw her alive on 17 Sept. 1946.

Immediate cause of death Peritonitis; fecal fistulae; gangrene of abdominal wall

Due to Ventral hernia

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. T. McSorley M. D.
Address Md. Gen. Hospital Date signed 17 Sept. 1946

122a

G43881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G43881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balto. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Williard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard SUMMERS

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-1478

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary C. Eckstorm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1904

8. AGE: Years	Months	Days	If less than one day
41	10	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Morton Sign Co.

FATHER
12. Name Charles
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Burrows
15. Birthplace Md.

16 (a) Informant Family
(b) Address 110 S. Williard St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 18 SEP 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1946, at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull
Intracranial hemorrhage
Contusion of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/12/46 at M.
(b) Where did injury occur 221 E. Baltimore St.
(c) Did injury occur at home, on farm, industrial place, in public place? Baltimore St. While at work? Yes
(d) Means of injury Fall from ladder

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/18/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43882 X ✓ G43882 Registered No.

G43882 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Do not use ditto marks. If unknown, write "unknown." Answer every question by a statement or a figure. Do not leave any blank unless instructed to do so. Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Somerset
(c) City or town Crisfield (If outside city or town limits, write RURAL and give town)
(d) Street No. Kawanna (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George M. Sterling

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Crisfield - Somerset - Md (Town, county, and state)
10. Usual Occupation Waterman
11. Industry or business Seafood

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Hospital Records
(b) Address University Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-46 (month) (day) (year)
(c) Cemetery or crematory Asbury Cem
Location Crisfield, Md

18 (a) Funeral director E. H. Harvey Broadway
(b) Address Crisfield, Md

19 (a) SEP 19 1946 (b) (Date received by registrar) Registrar

VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1946, at 10 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1946 to Sept 18 1946 and that I last saw h[illegible] alive on Sept 18 1946.

Immediate cause of death: Respiratory Failure
Due to Arteriosclerosis
Due to Bronchial asthma

Duration

Other Conditions Repaired femoral hernia
(Include pregnancy within 3 months of death)
Date of operation Sept 15 1946
Major findings of operation: Large opening to femoral canal
of autopsy not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. McCurdy M. D.
Address University Hospital Date signed 9-20-46

X

G43883
AB- 104578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43883 Registered No. 1226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 65Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Koserske

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-10-5955

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 21- 1882

8. AGE: Years	Months	Days	If less than one day
63	8	16 27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business D.E.Foote & Co

FATHER
12. Name Carl Koserke
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Reisner
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/46 (month) (day) (year)
(c) Cemetery or crematory ST. Paul Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henery Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) SEP 19 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1946, at 11.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17- 1946 to 9-17 1946, and that I last saw him alive on 9-17 1946

Immediate cause of death	Duration
Bronchopneumonia	-
Due to Intestinal Obstruction	-
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham, M.D.
Address Balto City Hosp Date signed 9 Sept 46

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

3 G43884 BALTIMORE CITY HEALTH DEPARTMENT ✓ G43884 Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6211 Plantview ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6211 Plantview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christopher A Pfeifer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Margaret nee Hughes 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9 1890

8. AGE: Years	Months	Days	If less than one day
55	11	8	hr. min.

9. Birthplace Pitts. Pa. (Town, county, and state)
10. Usual Occupation millwright
11. Industry or business Crown Cork & Steel

FATHER
12. Name Frank Pfeifer
13. Birthplace Pa.

MOTHER
14. Maiden Name Monica Lamburger
15. Birthplace Pa.

16 (a) Informant Mrs. Margaret Pfeifer wife
(b) Address 6211 Plantview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Fernhill Rd.

18 (a) Funeral director John J Connelly
(b) Address 418 Eastern Ave. Balto 21

19 (a) SEP 19 1946 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1946 to Sept 17 1946 and that I last saw him alive on Sept 17 1946

Immediate cause of death
(a) Uremia
(b) Arteriosclerosis
Due to (c) Chr Int Nephritis
Due to (d) Hypertension

Duration
3 mos
2 yrs
2 yrs
3 mos

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas J Kavanagh M.D.
Address 325 N Eden Apt 4 Date signed 9-18-46

X

G43885 BALTIMORE CITY HEALTH DEPARTMENT G43885
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 E. Lexington st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 E. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Sep

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22 1912

8. AGE: Years 34 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Pembroke, Ga (town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER 12. Name Elijah Simmons
13. Birthplace Florence S C

MOTHER 14. Maiden Name Etta Williams
15. Birthplace Ga

16 (a) Informant Laura Fries
(b) Address 1235 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) Huntington Williams M.D. (Registrar)

SEP 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18th 1946 at 3:34 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1946, to Sept 18th 1946, and that I last saw h alive on Sept 18th 1946

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd A. Lafond M. D.
Address 822 N. Broadway Date signed 9/18/46

FORM WHITE FOR USE WITH UNIFORM DEATH CERTIFICATE. Entries must be typewritten or written in ink. Every question must be answered. If unknown or not applicable, write word "unknown" or "not applicable," except that a person who has been married should not be returned as single, but the word "unknown" may be used if necessary. Certificate must be filed with the local registrar of the district in which death occurred before a burial permit is issued. Funeral director is responsible for seeing that all items are completed and correct. Age is especially important. Physicians: please write the causes of death clearly and legibly.

G43886 BC# G43886

BALTIMORE CITY HEALTH DEPARTMENT

G5616 4 CERTIFICATE OF DEATH X ✓ 159 Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Sollers Point Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Galacci

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-46

8. AGE: Years | Months | Days: 1/2 | If less than one day: hr. min.

9. Birthplace: md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Galacci
13. Birthplace Pa

MOTHER
14. Maiden Name Eunice Lancaster
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Local Johns Hopkins Medical School SEP 19 1946

18 (a) Funeral director 20096 Commissioner of Health
(b) Address
SEP 19 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946 at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946 to Sept 10 1946 and that I last saw him alive on Sept 10 1946

Immediate cause of death: PREMATURITY — Duration: 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H Handy M.D.
Address Johns Hopkins Hosp Date signed 9/11/46

VS 150

X

G43887.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164

G43887 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick C. Kaiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Margaret V. Kaiss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21st 1883

8. AGE: Years	Months	Days	If less than one day
63	3	28	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Railway Mail Clerk

11. Industry or business: U.S. Govt.

FATHER
12. Name: John Kaiss
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Balto. Md.

16 (a) Informant: John B. Myers Sr.
(b) Address: 331 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St

19 SEP 20 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1946, at 11 A.M.

21. I certify that I took charge of the remains described above, held an autopsy, and thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐, and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wound of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/19/46 10:30 A.M.
(b) Where did injury occur? 330 S. Ellwood ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury: Self inflicted gun shot

23. Signature: Howard J. Bruns M.D. Medical Examiner.
Date signed 9-19-46

G43888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G43888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Scott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Scott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Benson

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1892

8. AGE: Years 54 | Months 5 | Days 18 | If less than one day, hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas T. Rigg
13. Birthplace Maryland

MOTHER
14. Maiden Name Agge
15. Birthplace Germany

16 (a) Informant Charles A Benson
(b) Address 1012 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Fallon & Son Inc
(b) Address 1217 E Fort Ave

SEP 20 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946 at 9 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1946 to Sept 17 1946.
and that I last saw h alive on Sept 17 1946.

Immediate cause of death
My Coronation

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration 2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry E Bates

Address 517 Scott St Date signed 9/19/46 M. D.

VS 150

correct age is especially important. Physicians: please write the
the causes of death clearly and legibly.

G43889

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43889

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) ~~City or~~ town Hale Haven
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 Winans Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise M. Borcherding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) ~~Single~~, married, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ John H. Borcherding

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6th 1878

8. AGE: Years	Months	Days	If less than one day
68	0	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Robert Walker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lena Schwimmer
15. Birthplace Balto. Md.

16 (a) Informant Myrtle M. E. Slusher (Daughter)
(b) Address 726 Winans Ave - Hale Haven

17 (a) Burial (b) Date thereof 9/21/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams, M.D.

SEP 20 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1946, at 8:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Sept. 1946 to 18 Sept. 1946 and that I last saw her alive on 9/18/46 1946.

Immediate cause of death Pneumonia Primary

Due to pneumonitis & pleural effusion.

Due to

Other Conditions Ca. of stomach (Linitis plastica)

(Include pregnancy within 3 months of death)

Date of operation 9/15

Major findings of operation: Ca. of stomach.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Leyton, M.D.
Address Univ. Hosp. M. D. Date signed 9/18/46

X

FEMALE WHITES PRINT, WITH UNFADING INK. Be sure information shown is correctly supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43890

AB- 103881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

Registered No. G43890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 578 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sorrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17- 1860

8. AGE: Years	Months	Days	If less than one day
86	2	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Sorrell
13. Birthplace Va.

MOTHER
14. Maiden Name Rose?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore - Md.

18 (a) Funeral director Mrs. Francis H. Hendy
(b) Address 578 W Biddle St.

19 SEP 20 1946 Huntington Williams
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946 at 12 M Midnight

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19- 1946 to 9-18 1946, and that I last saw him alive on 9-18 1946.

Immediate cause of death Congestive Heart Failure.

Due to Rheumatic & Arteriosclerotic C-V Disease

Due to

Other Conditions ? Ruptured Valve - ? Aortic.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Fowler M. D.
Address Balto. City Hosps Date signed 9-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43891 ✓ G43891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Sinai Hosp 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 Chalgrove Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph A. Abrams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Hungary (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Hungary

MOTHER
14. Maiden Name —
15. Birthplace Hungary

16 (a) Informant Miss Clarice Abrams
(b) Address 5109 Chalgrove Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-46 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Rd.
Location

18 (a) Funeral director Jos Reina Jr
(b) Address 1439 E. Baltimore St.

19 (a) Received SEP 20 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1946 at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Sept 19 1946 and that I last saw him alive on Sept 15 1946

Immediate cause of death Pulmonary edema

Duration

Due to Hypertension & Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Bilateral bronchopneumonia Azotemia - Chronic Interstitial Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy: Edema of lungs, pulmonary edema, bilateral bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Irving Rubin M.D. M. D.
Address Sinai Hospital Date signed 9/19/46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3978 G43892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V45F

G43892 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Marylands) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Vine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth B Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race black | 6 (a) Single, married, widowed, or divorced divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-97

8. AGE: Years 49 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jeremiah Stafford
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Sutton
15. Birthplace Delaware

16 (a) Informant Meade
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Sam'l. W. Chase & Son
(b) Address 628 N. Eutaw St.

19 (a) SEP 20 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1946, at 11 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1946, to 9-19 1946, and that I last saw h alive on 9-19 1946.

Immediate cause of death Squamous cell Carcinoma
Transphanyx &
Due to Metastasis to skull

Duration 1yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. J. Davis
Address Johns Hopkins Hosp. Date signed 9/19/46

Huntington Williams, M.D.

G43893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G43893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6521 Colgate Avenue
(c) Hospital or institution:

26-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Colgate Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6521 Colgate Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Buchholz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/1863

8. AGE: Years 83 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Standard Oil Co

FATHER
12. Name George Buchholz
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Margaret Brehm
(b) Address 6521 Colgate Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Zeiler Sons
(b) Address 403 S. Wolfe Street

19 (SEP 20 1946 Registrar) Clinton Williams

MEDICAL CERTIFICATION A

20. DATE OF DEATH 9 / 18 / 1946 at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1946 to Sept 18 1946 and that I last saw h alive on 19

Immediate cause of death: Carcinoma of Stomach — Duration ?

Due to: Cardio Vascular Renal Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. McGarrigle M.D.
Address Brentald Md Date signed 9/18/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 107

Registered No. G43894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dutaland + Rayner Ave
(c) Hospital or institution: West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town Paradena P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William A Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	widowed

6 (b) Name of husband or wife Margaret Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	-	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Builder
11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Eliza Dietz
15. Birthplace Germany

16 (a) Informant Mr. Henry P. Smith
(b) Address Glen Burnie, Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/21/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemy
Location Fred. Ave. Balto. Md.

18 (a) Funeral director John O. Matchett & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) (b) Registrar

SEP 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1946, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1946 to 9-18 1946 and that I last saw him alive on 9-18 1946.

Immediate cause of death Acute Left Ventricular Dilatation — Duration

Due to Bilateral Bronchial Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bilateral Bronchial Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Berkowitz M.D.
Address West Baltimore Gen'l Hosp Signed 9/19/46

X

G43895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G43895 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct. Use full name of person—no initials or nicknames. Underlining or abbreviations not permitted. Cross out words not applicable. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 Windsor, Ave.
(c) Hospital or institution:

15-7

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Windsor, Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick A. Torsch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Fairchild
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 1/1/58

8. AGE: Years	Months	Days	If less than one day
88	8	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Canning
11. Industry or business Pres. Torsch Canning Co.

FATHER
12. Name Henry Torsch
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schaddelmann
15. Birthplace Germany

16 (a) Informant Mrs. Mary F. Torsch
(b) Address 3310 Windsor, Ave.

17 (a) Burial (Burial, cremation, entombment) (b) Date thereof 9/21/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location Woodlawn Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Signature of registrar) (b) Registrar

SEP 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19th 46 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1940 to Sept 19 1946, and that I last saw h[illegible] alive on Sept 19 1946.

Immediate cause of death	Duration
Pulmonary Edema	2 days
Due to Cls. Arteriosclerosis	Indefinite
Due to Hy. of radius	
Other Conditions Diabetes mellitus	Indefinite

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd St Date signed Sept 20 46

Huntington Williams, M.D. Registrar

937

G43896 — Joseph Burgess — G43896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hosp. 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Burgess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Negro	Widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-1877

8. AGE: Years	Months	Days	If less than 1 day: hr.	min.
69	—	—		

9. Birthplace PRINCE GEORGE, Md (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER — 12. Name JAMES BURGESS.
13. Birthplace Md.

MOTHER — 14. Maiden Name PRISCILLA ?
15. Birthplace Md.

16 (a) Informant Susie Scott
(b) Address 1225 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) (Date rec'd by registrar) (b) Registrar
SEP 20 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1946, at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1946 to 9/19 1946, and that I last saw him alive on 9/19 1946.

Immediate cause of death Respiratory & circulatory failure. — Duration

Due to Debility & cachexia

Due to Cancer of the esophagus.

Other Conditions Senility, Uremia.

(Include pregnancy within 3 months of death)

Date of operation Ca. of esophagus

Major findings of operation

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Leguton M. D.
Address Univ. Hosp. Date signed 9/19/46

G43897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G43897 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 W. Lee St
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 W. Lee St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Snowden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1880

8. AGE: Years 66 Months — Days — If less than one day hr. min.

9. Birthplace Edenton N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business Home —

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Thomas Kelly

(b) Address 617 W. Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md

18 (a) Funeral director Isaiah R Brown Son

(b) Address 1080 W Montgomery Street

19 (a) SEP 20 1946 (Date rec'd by Registrar) Registrar

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1946, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1946 to 9/17 1946 and that I last saw h[illegible] alive on 9/16 1946

Immediate cause of death Uraemia
Myocardial Deg.

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Frankel M. D.

Address 1700 Lee St Date signed 9/18/46

X

Please write plainly, with pen and ink. Use no abbreviations except those authorized by the Health Department. Fill in all blanks. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

G43898 Coster G43898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 E Lafayette Ave E-2
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Coster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara B. Coster

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Oct - 31 - 189

8. AGE: Years	Months	Days	If less than one day
58	10	18	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Tavern Proprietor

11. Industry or business

FATHER
12. Name James E. Coster Jr.
13. Birthplace Solomons Island

MOTHER
14. Maiden Name Eliza Jane Medley
15. Birthplace Solomons Island

16 (a) Informant Clara B. Coster
(b) Address 2300 E Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 21 - 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road & Gilley Ave

18 (a) Funeral director Fred E. Gilley Inc
(b) Address 2425 E. Oliver St.

19 (a) Date received SEP 20 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946 at 1130 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1946 to Sept 18 1946, and that I last saw him alive on Sept 18 1946

Immediate cause of death: Cardiac Dilatation — Duration 3 days

Due to: Acute Myocarditis — 5 yrs

Due to: Arterial Hypertension — 5 yrs

Due to: Chronic Interstitial Nephritis — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Asseberg
Address 3015 E. North Ave Date signed 9-19-46 (M. D.)

VS 150

X

G43899 HECKMAN. G43899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 E 23rd St
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 E 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Pauline Heckman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Thilhorn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 10, 1869

8. AGE: Years 77 | Months 0 | Days 9 | If less than one day: hr. min.

9. Birthplace: Louisville Ky
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name (Unknown) Norman
13. Birthplace Ky

MOTHER
14. Maiden Name Mary Estes
15. Birthplace Ky

16 (a) Informant: Thilhorn Heckman
(b) Address 737 E 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/46 (month) (day) (year)
(c) Cemetery or crematory: Louisville
Location: Louisville Ky

18 (a) Funeral director: Thilhorn & Kirby
(b) Address 1219 Park Ave

SEP 20 1946 (Date rec'd by Local Registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1946, at 8:10 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1946 to Sept 19 1946 and that I last saw him alive on Sept 19 1946

Immediate cause of death: Uremia — Duration

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack F. Slaughter, M.D.
Address 50 E North Ave Date signed 9-20-46

VS 150

6 For S. R. Davis, by Howard D. Hendrix, M.D. X

Please write plainly, with unfading ink. Items must be correct and complete. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43900 Registered No.

23-2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town li[illegible] and give town)
(d) Street No. 14 Poultney St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE OEHS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW?

6 (b) Name of husband or wife ADOLPH —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG-19-1869

8. AGE: Years	Months	Days	If less than one day
77	1	1	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name CONRAD SCHLEICH.
13. Birthplace GERMANY.

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace " "

16 (a) Informant ALBERT SCHLEICH.
(b) Address 14 POULTNEY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 23-46 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD BALTO. MD

18 (a) Funeral director Bernard E Harle
(b) Address 121 E West St.

19 (a) [illegible] Registrar

SEP 20 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 19 46 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 19 46 to 9-20 19 46 and that I last saw her alive on 9-19 19 46

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to HYPERTENSION	
Due to Cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert L Grundell M.D.
Address 1211 Light St Date signed 9-20-46

X

G43901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G43901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made for information insofar as it is available. If any item is unknown, so state. Do not omit any item or make any erasure. Do not abbreviate. Write out the full name of the city or town. Give the street address or location in city or town. Fill in all blanks for which you have the information. Be sure that the cause of death is clearly and legibly stated. Consult the physician, undertaker, or other informant for information not known to you. Be sure that you answer each question. Be sure that the certificate is signed. Be sure that the certificate is dated. Be sure that the certificate is witnessed. Be sure that the certificate is sealed. Be sure that the certificate is delivered. Be sure that the certificate is recorded. Be sure that the certificate is filed. Be sure that the certificate is preserved. Be sure that the certificate is destroyed. Be sure that the certificate is lost. Be sure that the certificate is found. Be sure that the certificate is returned. Be sure that the certificate is replaced. Be sure that the certificate is corrected. Be sure that the certificate is amended. Be sure that the certificate is revoked. Be sure that the certificate is cancelled. Be sure that the certificate is void. Be sure that the certificate is invalid. Be sure that the certificate is valid. Be sure that the certificate is genuine. Be sure that the certificate is authentic. Be sure that the certificate is official. Be sure that the certificate is legal. Be sure that the certificate is binding. Be sure that the certificate is enforceable. Be sure that the certificate is effective. Be sure that the certificate is operative. Be sure that the certificate is in force. Be sure that the certificate is in effect. Be sure that the certificate is in operation. Be sure that the certificate is in use. Be sure that the certificate is in circulation. Be sure that the certificate is in existence. Be sure that the certificate is in being. Be sure that the certificate is in life. Be sure that the certificate is in death. Be sure that the certificate is in the past. Be sure that the certificate is in the present. Be sure that the certificate is in the future. Be sure that the certificate is in the world. Be sure that the certificate is in the universe. Be sure that the certificate is in the cosmos. Be sure that the certificate is in the infinite. Be sure that the certificate is in the eternal. Be sure that the certificate is in the divine. Be sure that the certificate is in the sacred. Be sure that the certificate is in the holy. Be sure that the certificate is in the blessed. Be sure that the certificate is in the glorious. Be sure that the certificate is in the heavenly. Be sure that the certificate is in the celestial. Be sure that the certificate is in the angelic. Be sure that the certificate is in the seraphic. Be sure that the certificate is in the cherubic. Be sure that the certificate is in the archangelic. Be sure that the certificate is in the principalities. Be sure that the certificate is in the powers. Be sure that the certificate is in the virtues. Be sure that the certificate is in the dominions. Be sure that the certificate is in the thrones. Be sure that the certificate is in the cherubim. Be sure that the certificate is in the seraphim. Be sure that the certificate is in the trinity. Be sure that the certificate is in the father. Be sure that the certificate is in the son. Be sure that the certificate is in the holy ghost. Be sure that the certificate is in the holy spirit. Be sure that the certificate is in the holy trinity. Be sure that the certificate is in the holy family. Be sure that the certificate is in the holy church. Be sure that the certificate is in the holy sacrament. Be sure that the certificate is in the holy communion. Be sure that the certificate is in the holy eucharist. Be sure that the certificate is in the holy mass. Be sure that the certificate is in the holy sacrifice. Be sure that the certificate is in the holy redemption. Be sure that the certificate is in the holy salvation. Be sure that the certificate is in the holy grace. Be sure that the certificate is in the holy mercy. Be sure that the certificate is in the holy love. Be sure that the certificate is in the holy charity. Be sure that the certificate is in the holy faith. Be sure that the certificate is in the holy hope. Be sure that the certificate is in the holy virtues. Be sure that the certificate is in the holy gifts. Be sure that the certificate is in the holy fruits. Be sure that the certificate is in the holy beatitudes. Be sure that the certificate is in the holy commandments. Be sure that the certificate is in the holy precepts. Be sure that the certificate is in the holy counsels. Be sure that the certificate is in the holy evangelical counsels. Be sure that the certificate is in the holy religious vows. Be sure that the certificate is in the holy religious life. Be sure that the certificate is in the holy religious state. Be sure that the certificate is in the holy religious order. Be sure that the certificate is in the holy religious congregation. Be sure that the certificate is in the holy religious community. Be sure that the certificate is in the holy religious institute. Be sure that the certificate is in the holy religious society. Be sure that the certificate is in the holy religious association. Be sure that the certificate is in the holy religious union. Be sure that the certificate is in the holy religious federation. Be sure that the certificate is in the holy religious confederation. Be sure that the certificate is in the holy religious league. Be sure that the certificate is in the holy religious alliance. Be sure that the certificate is in the holy religious coalition. Be sure that the certificate is in the holy religious fellowship. Be sure that the certificate is in the holy religious brotherhood. Be sure that the certificate is in the holy religious sisterhood. Be sure that the certificate is in the holy religious family. Be sure that the certificate is in the holy religious household. Be sure that the certificate is in the holy religious home. Be sure that the certificate is in the holy religious dwelling. Be sure that the certificate is in the holy religious abode. Be sure that the certificate is in the holy religious habitation. Be sure that the certificate is in the holy religious residence. Be sure that the certificate is in the holy religious domicile. Be sure that the certificate is in the holy religious mansion. Be sure that the certificate is in the holy religious palace. Be sure that the certificate is in the holy religious castle. Be sure that the certificate is in the holy religious fortress. Be sure that the certificate is in the holy religious stronghold. Be sure that the certificate is in the holy religious refuge. Be sure that the certificate is in the holy religious sanctuary. Be sure that the certificate is in the holy religious temple. Be sure that the certificate is in the holy religious church. Be sure that the certificate is in the holy religious cathedral. Be sure that the certificate is in the holy religious basilica. Be sure that the certificate is in the holy religious chapel. Be sure that the certificate is in the holy religious oratory. Be sure that the certificate is in the holy religious shrine. Be sure that the certificate is in the holy religious monastery. Be sure that the certificate is in the holy religious convent. Be sure that the certificate is in the holy religious abbey. Be sure that the certificate is in the holy religious priory. Be sure that the certificate is in the holy religious friary. Be sure that the certificate is in the holy religious hermitage. Be sure that the certificate is in the holy religious cloister. Be sure that the certificate is in the holy religious seminary. Be sure that the certificate is in the holy religious college. Be sure that the certificate is in the holy religious university. Be sure that the certificate is in the holy religious school. Be sure that the certificate is in the holy religious academy. Be sure that the certificate is in the holy religious institute. Be sure that the certificate is in the holy religious library. Be sure that the certificate is in the holy religious museum. Be sure that the certificate is in the holy religious gallery. Be sure that the certificate is in the holy religious theater. Be sure that the certificate is in the holy religious concert hall. Be sure that the certificate is in the holy religious opera house. Be sure that the certificate is in the holy religious ballet. Be sure that the certificate is in the holy religious dance. Be sure that the certificate is in the holy religious music. Be sure that the certificate is in the holy religious song. Be sure that the certificate is in the holy religious hymn. Be sure that the certificate is in the holy religious psalm. Be sure that the certificate is in the holy religious prayer. Be sure that the certificate is in the holy religious meditation. Be sure that the certificate is in the holy religious contemplation. Be sure that the certificate is in the holy religious adoration. Be sure that the certificate is in the holy religious worship. Be sure that the certificate is in the holy religious praise. Be sure that the certificate is in the holy religious thanksgiving. Be sure that the certificate is in the holy religious petition. Be sure that the certificate is in the holy religious intercession. Be sure that the certificate is in the holy religious supplication. Be sure that the certificate is in the holy religious confession. Be sure that the certificate is in the holy religious penance. Be sure that the certificate is in the holy religious absolution. Be sure that the certificate is in the holy religious reconciliation. Be sure that the certificate is in the holy religious communion. Be sure that the certificate is in the holy religious eucharist. Be sure that the certificate is in the holy religious mass. Be sure that the certificate is in the holy religious sacrifice. Be sure that the certificate is in the holy religious redemption. Be sure that the certificate is in the holy religious salvation. Be sure that the certificate is in the holy religious grace. Be sure that the certificate is in the holy religious mercy. Be sure that the certificate is in the holy religious love. Be sure that the certificate is in the holy religious charity. Be sure that the certificate is in the holy religious faith. Be sure that the certificate is in the holy religious hope. Be sure that the certificate is in the holy religious virtues. Be sure that the certificate is in the holy religious gifts. Be sure that the certificate is in the holy religious fruits. Be sure that the certificate is in the holy religious beatitudes. Be sure that the certificate is in the holy religious commandments. Be sure that the certificate is in the holy religious precepts. Be sure that the certificate is in the holy religious counsels. Be sure that the certificate is in the holy religious evangelical counsels. Be sure that the certificate is in the holy religious religious vows. Be sure that the certificate is in the holy religious religious life. Be sure that the certificate is in the holy religious religious state. Be sure that the certificate is in the holy religious religious order. Be sure that the certificate is in the holy religious religious congregation. Be sure that the certificate is in the holy religious religious community. Be sure that the certificate is in the holy religious religious institute. Be sure that the certificate is in the holy religious religious society. Be sure that the certificate is in the holy religious religious association. Be sure that the certificate is in the holy religious religious union. Be sure that the certificate is in the holy religious religious federation. Be sure that the certificate is in the holy religious religious confederation. Be sure that the certificate is in the holy religious religious league. Be sure that the certificate is in the holy religious religious alliance. Be sure that the certificate is in the holy religious religious coalition. Be sure that the certificate is in the holy religious religious fellowship. Be sure that the certificate is in the holy religious religious brotherhood. Be sure that the certificate is in the holy religious religious sisterhood. Be sure that the certificate is in the holy religious religious family. Be sure that the certificate is in the holy religious religious household. Be sure that the certificate is in the holy religious religious home. Be sure that the certificate is in the holy religious religious dwelling. Be sure that the certificate is in the holy religious religious abode. Be sure that the certificate is in the holy religious religious habitation. Be sure that the certificate is in the holy religious religious residence. Be sure that the certificate is in the holy religious religious domicile. Be sure that the certificate is in the holy religious religious mansion. Be sure that the certificate is in the holy religious religious palace. Be sure that the certificate is in the holy religious religious castle. Be sure that the certificate is in the holy religious religious fortress. Be sure that the certificate is in the holy religious religious stronghold. Be sure that the certificate is in the holy religious religious refuge. Be sure that the certificate is in the holy religious religious sanctuary. Be sure that the certificate is in the holy religious religious temple. Be sure that the certificate is in the holy religious religious church. Be sure that the certificate is in the holy religious religious cathedral. Be sure that the certificate is in the holy religious religious basilica. Be sure that the certificate is in the holy religious religious chapel. Be sure that the certificate is in the holy religious religious oratory. Be sure that the certificate is in the holy religious religious shrine. Be sure that the certificate is in the holy religious religious monastery. Be sure that the certificate is in the holy religious religious convent. Be sure that the certificate is in the holy religious religious abbey. Be sure that the certificate is in the holy religious religious priory. Be sure that the certificate is in the holy religious religious friary. Be sure that the certificate is in the holy religious religious hermitage. Be sure that the certificate is in the holy religious religious cloister. Be sure that the certificate is in the holy religious religious seminary. Be sure that the certificate is in the holy religious religious college. Be sure that the certificate is in the holy religious religious university. Be sure that the certificate is in the holy religious religious school. Be sure that the certificate is in the holy religious religious academy. Be sure that the certificate is in the holy religious religious institute. Be sure that the certificate is in the holy religious religious library. Be sure that the certificate is in the holy religious religious museum. Be sure that the certificate is in the holy religious religious gallery. Be sure that the certificate is in the holy religious religious theater. Be sure that the certificate is in the holy religious religious concert hall. Be sure that the certificate is in the holy religious religious opera house. Be sure that the certificate is in the holy religious religious ballet. Be sure that the certificate is in the holy religious religious dance. Be sure that the certificate is in the holy religious religious music. Be sure that the certificate is in the holy religious religious song. Be sure that the certificate is in the holy religious religious hymn. Be sure that the certificate is in the holy religious religious psalm. Be sure that the certificate is in the holy religious religious prayer. Be sure that the certificate is in the holy religious religious meditation. Be sure that the certificate is in the holy religious religious contemplation. Be sure that the certificate is in the holy religious religious adoration. Be sure that the certificate is in the holy religious religious worship. Be sure that the certificate is in the holy religious religious praise. Be sure that the certificate is in the holy religious religious thanksgiving. Be sure that the certificate is in the holy religious religious petition. Be sure that the certificate is in the holy religious religious intercession. Be sure that the certificate is in the holy religious religious supplication. Be sure that the certificate is in the holy religious religious confession. Be sure that the certificate is in the holy religious religious penance. Be sure that the certificate is in the holy religious religious absolution. Be sure that the certificate is in the holy religious religious reconciliation.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 Marydale Road
(c) Hospital or institution: 25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Marydale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY R. WILLIE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma L. Willie
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 29 Aug. 1882

8. AGE: Years	Months	Days	If less than one day
64	-	20	********** min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business Pistorio Prefab. Co.

FATHER
12. Name Charles W. Willie
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Stoll
15. Birthplace Germany

16 (a) Informant Mrs. Emma L. Willie
(b) Address 306 Marydale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 21 Sept. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director A. B. Kilpatrick & Son
(b) Address 1300 Eutaw Place. 17

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. 332 S. Frederick Ave Registrar

VS 15 SEP 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept. 46 19 , at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 19 46 to Sept 18 19 46, and that I last saw ~~him~~ alive on Sept 16 19 46

Immediate cause of death: Cardiac failure

Due to Metastatic cancer (Stomach) ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Williamson M.D.
Address 332 S. Frederick Ave Date signed 9/19/46

Dr. Williamson. X

643902 Over BALTIMORE CITY HEALTH DEPARTMENT 643903
CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 11-4
(a) Baltimore City, Maryland
(b) Street address Richwood & Druid Pk.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 McCulloh (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Mc Daniel
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	B	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/14/46

8. AGE: Years	Months	Days	If less than one day
		1	40 hr. min.

9. Birthplace Univ. Hosp., Baltimore, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Floyd M. E. McDaniels
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Katie Pearson
15. Birthplace Baltimore Md.

16 (a) Informant Katie M. E. McDaniels
(b) Address 1208 McCulloh St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: University Medical School SEP 20 1946

18 (a) Funeral director Commissioner of Health
(b) Address
19 SEP 20 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1946, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1946, to 9-16 1946, and that I last saw him alive on 9-15 1946.

Immediate cause of death Atelectasis of lungs — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Holmes M. D.
Address Univ. Hosp. Date signed 9-16-46

43903 Over BALTIMORE CITY HEALTH DEPARTMENT G43903
CERTIFICATE OF DEATH 161a Registered No.

16-3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Greene St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 N Vincent St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Dupree
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	—

6 (b) Name of husband or wife none —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/12/46

8. AGE: Years	Months	Days	If less than one day
		7	hr. 15 min.

9. Birthplace University Hospital (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Joseph Dupree
13. Birthplace MD

MOTHER 14. Maiden Name Margaret Dupree
15. Birthplace MD

16 (a) Informant —
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 20 1946
18 (a) Funeral director Commissioner of Health
(b) Address
19 SEP 20 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 1946

20. DATE OF DEATH 9/19 1946 at 1/10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1946 to 9/19 1946, and that I last saw her alive on 9/19 1946.

Immediate cause of death aspiration of vomitus and aspiration asphyxia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gly Mansenburg M.D.
Address University Hosp signed 9/19/46

VS 186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G43901

AB-104312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G43901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 85yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Clairmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Ruggiero

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Ferdinand (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1859

8. AGE: Years	Months	Days	If less than one day
87	2	16	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Pessagno
13. Birthplace Italy

MOTHER
14. Maiden Name Louise ?
15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Tully + Zeller 640 S. Wolfe St

18 (a) Funeral director
(b) Address Huntington Williams, MD

SEP 20 1946 (Local registrar) Registered

MEDICAL CERTIFICATION AM

20. DATE OF DEATH September 20 1946, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1946 to 9-20- 1946 and that I last saw h 9r alive on 9-20- 1946.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions Amputation left forearm — postoperative stage
(Include pregnancy within 3 months of death)

Date of operation 9/9/46

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Tibbs M. D.
Address Balti. City Hosp. Date signed 9/20/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710

G43905 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Caul Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Stanon Stephen Graham Vickery (Stephen Graham)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age – years
7. Birth date of deceased (mo., day, yr.): Jan-31-1868
8. AGE: Years 78 | Months 7 | Days 19 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business –

FATHER
12. Name Edw. M. Vickery
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Augusta Henderson
15. Birthplace London Eng.

16 (a) Informant Mr. Chas Playford (Son in law)
(b) Address Cumberland Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md.

18 (a) Funeral director Stinson Mason & Co.
(b) Address 108 W. Mt. Ave.

19 (a) Registrar's signature Huntington Williams M.D.
(b) Date received SEP 21 1946

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1946 at 11 35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial hemorrhage, Fracture and dislocation of 6th cervical vertebra

Other Conditions Fractured ribs, Coronary disease.
(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-46 11:2 P.M.
(b) Where did injury occur Cathedral & Preston Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell struck by trolley

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 9-19-46

G43906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 567

G43906
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Wildwood Pkwy. - 29
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH EMERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-31-1917

8. AGE: Years 29 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Policeman

11. Industry or business

FATHER
12. Name James Emerson
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Bilstein
15. Birthplace Md.

16 (a) Informant James Emerson (Father)
(b) Address Easton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-1946 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Ave.
Location Easton - Md.

18 (a) Funeral director Stewart Mowen & Co
(b) Address 1019 N. Patterson Ave. City #1

SEP 21 1946
(Date filed by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 20 1946, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 20 1946 to SEPT 20 1946, and that I last saw him alive on SEPT 20 1946.

Immediate cause of death INTRA CEREBRAL HEMORRHAGE — Duration

Due to PROBABLE BRAIN TUMOR

Due to HEMORRHAGE INTO VENTRICLE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: AUTOPSY.

of autopsy INTRA CEREBRAL HEMORRHAGE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R E Bauer M. D.
Address Univ. Hosp. Date signed 9-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item for information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 150

G43907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G43907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution:
Cold Spring Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo. 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Hayward Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANKLIN—, HARVEY WILLIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife deceased Edna M. Franklin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1874

8. AGE: Years	Months	Days	If less than one day
71	9	27	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Farmer--retired

11. Industry or business

FATHER
12. Name Nathan Franklin
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha E. Grimes
15. Birthplace Maryland

16 (a) Informant Robt. L. Steel
(b) Address 4101 Hayward Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-46 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Sams Creek Brethren
Location Dennings, Carroll Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

SEP 21 1946

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1946 to Sept 19 1946, and that I last saw him alive on Sept. 19 1946.

	Duration
Immediate cause of death BILATERAL PNEUMONIA	2 days.
Due to CHRONIC MYOCARDITIS	10 yrs.
Due to —	
Other Conditions CEREBRAL EMBOLISM	6 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R Kleeman M. D.
Address 3803 Edmondson. Date signed 9/20/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Give correct age in especially important. Physicians: please write this

643903 (3)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 643903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 152X Argyle Ave
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 152X Argyle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Thomas Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1867

8. AGE: Years	Months	Days	If less than one day
79	-	-	hr. min.

9. Birthplace A. A. Co Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Catherine Owens
(b) Address 152X Argyle Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-20-46 (day) (year)
(c) Cemetery or crematory Mrs Cathedral
Location Balto. Md.

18 (a) Funeral director Archibald B. Lyall
(b) Address Lyall and Sullivan
SEP 21 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1945 to Sept 17 1946 and that I last saw h alive on Sept 17 1946.

Immediate cause of death Cardio Vascular Disease — Duration 1 yr.

Due to Cerebral Hemorrhage — Duration 6 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Nature of injury

23. Signature H. William Frey M. D.
Address 25 Iowa Ave Date signed 9/20/46

X

643909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 643909

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 649 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 649 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giacinda Dadduria

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Domenic
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 28, 1878

8. AGE: Years: 68 Months: 6 Days: 22 If less than one day: hr. min.

9. Birthplace: Italy (town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Fernod Dunggnies
13. Birthplace: Italy

MOTHER
14. Maiden Name: Nunzata Dunggnies
15. Birthplace: Italy

16 (a) Informant: Vincent Di Carlo
(b) Address: 10 Mayflower Court

17. Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Balto. Md.

18 (a) Funeral director: Wilbur Coffroth
(b) Address: 1217 E. Fayette St.

19. SEP 21 1946 (Date rec'd by registrar) Hamilton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6. 1946 to Sept 20 1946
and that I last saw h alive on 19

Immediate cause of death	Duration
Chronic Myocarditis	1 yr.
Due to Old Age.	
Due to Terminal Pneumonia	3 da.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Herbert E. Blake M. D.
Address: Med. Arts Bldg. Date signed 9-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G43910

500131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 587

G43910 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 E. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theron Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-8607

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-?-02

8. AGE: Years	Months	Days	If less than one day
44	6		hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Thomas J Miller
13. Birthplace md

MOTHER
14. Maiden Name Nellie O. Brien
15. Birthplace md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 SEP 21 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1946, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to Sept 19 1946 and that I last saw him alive on Sept 19 1946.

Immediate cause of death	Duration
? Coronary occlusion	24 hrs.
Due to Subacute bacterial endocarditis	2 mos.
Due to Streptococcus salivarius	
Other Conditions Rheumatic Ht. Disease	Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip J. Magley M. D.
Address Johns Hopkins Hosp. Date signed Sept 20

G43911

BALTIMORE CITY HEALTH DEPARTMENT X V G43911

CERTIFICATE OF DEATH 93c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eutaw Avenue
(c) Hospital or institution:
Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Kalorama Rd. N. W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Cleary

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: William Cleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name R. Lawrence Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Middleton
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 9/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 SEP 21 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946, at 10.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Respiratory Failure
Cardiac Failure
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions: Rheumatoid arthritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address D.C. Gen. Hosp. Date signed 9-20-46

X

Please write plainly, with ink. Spell out full names and do not use abbreviations. Give the usual residence of the deceased, whether inside or outside the city limits, and the actual place of death. Be sure to answer each question. If the information requested is unknown or does not apply, state "unknown" or "none" so that there may be no omissions. Give the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

G43912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 C

Registered No. G43912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Keene Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Keene Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie M. Stockdale

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband or wife: Edward A. Stockdale
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 17th 1861

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	1	2		

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business: Self

FATHER
12. Name: Thomas Parlett
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elizabeth Sadler
15. Birthplace: Md.

16 (a) Informant: Geo. W. Stockdale
(b) Address: 2526 Harlem Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory: Presbyterian
Location: Govans
18 (a) Funeral director: Wm. Cook Inc.
(b) Address: 1312 St. Paul St
19 (a) SEP 21 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19th 1946 2:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Sept. 1946 to 19 Sept. 1946, and that I last saw her alive on 19 Sept. 1946

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	10 yrs.
Due to	
Due to	
Other Conditions: Arthritis Deformans (Include pregnancy within 3 months of death)	15 yrs.

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm. H. Kammer M.D.
Address 501 Sheridan Ave Date signed 20 Sept 1946

VS 150

G43913
AB-104555

Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30F

Registered No. G43913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Allen-Twin A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16-1946

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Walter Nest Allen
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Rebecca Brooks
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated 3 PM (b) Date thereof 9-18-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 SEP 21 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17- 1946, at 7.55a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16- 1946 to 9-17 1946, and that I last saw h im alive on 9-17 1946

Immediate cause of death	Duration
Pulmonary Atelectasis	12 hrs.
Due to Premature ty	
Due to	
Other Conditions 1 - Ot. hydrocephalus 2-Liver changes consd. w/ live	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Thomas Bloom M.D.
M. D.

Address Baltimore City Hos. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or "unknown" or "none" entered as the case may be. Cause of death must be certified by a physician, if any physician attended deceased during last illness; otherwise by coroner. Cover, if information known or obtainable. If not, write "unknown." Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43914 — 2L - 100013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G43913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2136 Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1859

8. AGE: Years	Months	Days	If less than one day
86 yrs	9	0	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Richardson
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Dukes
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21st 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo F. Cook
(b) Address 4701 & 03 Patterson Park Ave

19 (a) SEP 21 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946, at 10:54pm

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19 1946 to Sept. 19 1946 and that I last saw h in alive on Sept. 19 1946

Immediate cause of death Cardiac Failure — Days

Due to Arteriosclerotic & Coronary Artery Disease.

Due to Generalized Arteriosclerosis

Other Conditions Pulmonary Tbc. Old inactive. Nephrosclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: See above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto. City Hosps Date signed 9-19-46

94a

G43915

382906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G43915 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Preston (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Strody Little (Hunter)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 /1909

8. AGE: Years	Months	Days	If less than one day
36	4		hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Rufus Moore

13. Birthplace N.C.

MOTHER 14. Maiden Name Amy McCalip

15. Birthplace N.C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof SEPT 26 46 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location STAR, N.C.

18 (a) Funeral director Chas. H. Alexander

(b) Address 1200 Mallet St.

19 SEP 21 1946 Lexington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1946, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1946, to Sept 20 1946, and that I last saw her alive on Sept 20 1946.

Immediate cause of death	Duration
Acidosis & Dehydration	
Due to Bowel regurgitation and High Obstruction for	
Due to Cyanophospathia	
Other Conditions Leucocytosis	10 yr.

(Include pregnancy within three months of death)

Date of operation 8/3/46

Major findings of operation: Cyanophospathia Leu. Col

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bruce J. Franz M. D.

Address Johns Hopkins Hospital Date signed 9-20-46

VS 150

G43916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G43916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Brentwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Justus P. Beauchamp

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Elizabeth Beauchamp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1869

8. AGE: Years 77 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace Hyacinth, Virginia (town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER — 12. Name William Beauchamp
13. Birthplace Virginia

MOTHER — 14. Maiden Name Unknown Beauchamp
15. Birthplace Virginia

16 (a) Informant William Beauchamp
(b) Address 1016 Brentwood Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-21-46 (month) (day) (year)
(c) Cemetery or crematory Henderson Cemetery
Location Hyacinth, Virginia

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

(Date rec'd) SEP 21 1946 (Signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1946, at 6 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1946 to 9/21 1946, and that I last saw him alive on 9/20/46 19

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to Enterocolitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sol Fruit

Address 1223 E. 31st St. Date signed 9/21/46 M. D.

G43917.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 32a ✓

Registered No. G43917.

PLEASE WRITE PLAINLY. With INDELIBLE INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Andover Nursery Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dubalsky or Dobrowski ✓

3 (b) If veteran, name war: W.W. 2

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) 12-15-[illegible]

8. AGE: Years 29 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace West Virginia (State, county, and state)

10. Usual Occupation Refrig. mechanic

11. Industry or business

FATHER: 12. Name Joseph
13. Birthplace

MOTHER: 14. Maiden Name Eve
15. Birthplace

16 (a) Informant Mr. Louis Dubalsky
(b) Address 1459 Reynolds Ave

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Sept 23-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn

18 (a) Funeral director John A. Strebhaus & Son
(b) Address 1423 S. Paca St

19 (a) SEP 21 1946 (Date received by local reg.) (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1946, at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1946 to 9/17 1946, and that I last saw him alive on 9/19 1946.

Immediate cause of death: Coronary failure
due to Acute Pneumonia
Due to Weils Disease
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed M. D.

X

G43918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. G43918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herrington
(c) Hospital or institution Lyndenhurst Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E. Preston St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Joan Irene Kendrick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1935

8. AGE: Years 10 | Months 11 | Days 26 | If less than one day — hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name William T. Kendrick
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alice Bowman
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 1913 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd

19 (a) [illegible] Huntington Williams SEP 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946, to Sept 20 1946 and that I last saw him alive on Sept 20 1946.

Immediate cause of death	Duration
Myocarditis	
Due to Diphtheria	8 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron G. Tull
M. D.
Address [illegible] Date signed

MYRON G. TULL, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G43919

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43919

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. CALHOUN ST.
(c) Hospital or institution: FRANKLIN Sq. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town EDGEMERE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 WELLS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH BATHORY

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife GABRIEL BATHORY
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JULY 22, 1896

8. AGE: Years	Months	Days	If less than one day
50	1	28	hr. min.

9. Birthplace HUNGARY (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name FRANK ILLOSVY
13. Birthplace HUNGARY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant GABRIEL BATHORY
(b) Address 3001 WELLS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 24 46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

SEP 21 1946 (b) Huntington Williams, M.D. Franklin Sq. Hosp.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946 at 2:55 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Sept 20 1946, and that I last saw her alive on Sept 16 1946.

Immediate cause of death	Duration
Subarachnoid Hemmorrhage	4 d.
Due to Hypertension and	5-8 years
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D. Address Franklin Sq. Hosp. Date signed 9/24/46

G43920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946

G43920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 LIGHT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 LIGHT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS LOUIS CRAIG

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife VIRGINIA M. SAUERHOFF
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB 3 1877

8. AGE: Years	Months	Days	If less than one day
69	7	18	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation RAIL ROAD
11. Industry or business BALTIMORE & OHIO

FATHER
12. Name THOMAS CRAIG
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name AMANDA CROUCH
15. Birthplace MARYLAND

16 (a) Informant VIRGINIA M. CRAIG.
(b) Address 904 LIGHT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 23 46 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location ANNAPOLIS BLVD.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

SEP 21 1946 (Date received by Registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 21 1946 (Month) (Day) (Year) 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 7 P.M. 1946
and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis	
Due to Ht	
Other Conditions Right pyelonephritis	1 year

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Isaac Miller M. D.
Address 721 S. Chapel St

X 9/21/46

G43921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

Registered No. G43921

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dallas E. LONG

3 (b) If veteran, name war WORLD WAR II

3 (c) Social Security Account No. 236-12-5931

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife WANDA VIOLA MOORE

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) AUG 1, 1911

8. AGE: Years 35 | Months 1 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business

FATHER
12. Name EDWARD LONG
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden Name PEARL PHILLIPS
15. Birthplace WEST VIRGINIA

16 (a) Informant I. E. STURM
(b) Address 121 W. BARRIE

17 (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** 9 21 46 (month) (day) (year)
(c) Cemetery or crematory PHILIPPI CEM.
Location PHILIPPI, WEST VIRGINIA

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) SEP 21 1946 (Date rec'd by Registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946 at 11:26 a. M.

21. I certify that I took charge of the remains described above, held an autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema
Dilatation of right ventricle of heart
Due to Necrosis of esophagus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/19/46

VS 19t

G43922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

Registered No. G43922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914- Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Late James A Boone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1880

8. AGE: Years 66 Months 4 Days - If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John W Harris
13. Birthplace Penn.

MOTHER 14. Maiden Name Francis Gwyn.
15. Birthplace Va.

16 (a) Informant Anna Flannigan
(b) Address 914 Wash Blvd.

17 (a) Burial (b) Date thereof Sept 21.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick ave

18 (a) Funeral director Harry H Welsh
(b) Address 1116 Edmondson ave

19 (a) SEP 21 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1946, at 9 25 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tertiary syphilis with destruction of nose & nasal septum and perforation of palate.

Due to Extreme emaciation

Other Conditions Atrophy and flexion deformities of all extremities

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/20/46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43923 BC# G53691

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43923
CERTIFICATE OF DEATH 30F
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution St Joseph's Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Louth Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sharon K Forwood

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1946

8. AGE: Years	Months	Days	If less than one day
	1	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Daniel W. Forward
13. Birthplace Md.

MOTHER
14. Maiden Name Maxine Crosswhite
15. Birthplace W. Va.

16 (a) Informant Mr. Daniel Forward
(b) Address 3420 Louth Road, Dundalk

17 (a) Burial (b) Date thereof 9/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) SEP 21 1946 (b) Huntington Williams, M.D.
(Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20th 1946, at 7:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1946, to Sept 20th 1946, and that I last saw h[illegible] alive on Sept 20th 1946.

Immediate cause of death: Cardio-Respiratory Failure due Pulmonary Edema — Duration
Due to: Portal Obstruction
Due to: Congenital Lues
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Pulmonary edema, Enlarged Hepatic Lymph Glands, Portal Obstruction, Blood in [illegible]
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Wells M.D.
Address Johns Hopkins Hosp Date signed 9-20-46

VS 150

G43924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G43924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Druid Hill
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Druid Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick J. Duckett

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24-1883

8. AGE: Years	Months	Days	If less than one day
63	5	26	hr. min.

9. Birthplace Charles Co. Md (Town, county, and state)

10. Usual Occupation Trucking Business

11. Industry or business

FATHER
12. Name Joe F. Duckett
13. Birthplace Charles Co. Md

MOTHER
14. Maiden Name Matilda Brawner
15. Birthplace Charles Co. Md

16 (a) Informant Joseph Duckett
(b) Address 1727 Druid Hill Ave

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-22-46 (month) (day) (year)

(c) Cemetery or crematory Mt Zion
Location Balto Co

18 (a) Funeral director Mrs George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) SEP 21 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Sept 19 1946 and that I last saw h[illegible]live on Aug 21 1946.

Immediate cause of death Cardiac Disease — Duration

Due to

Due to Rheumatism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Woolridge
Address Ellicott City Md Date signed 9-23-46

G43925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. G43925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the c the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs 14
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME O. Ruth Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edward A. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1895

8. AGE: Years 51 | Months - | Days 9 | If less than one day hr. min.

9. Birthplace Norfolk (Town, county, and state)

10. Usual Occupation Public Health Nurse

11. Industry or business

MOTHER / FATHER

12. Name John H. Johnson

13. Birthplace Norfolk Va Baltimore, Md

14. Maiden Name Ruby E. Davis

15. Birthplace Norfolk Va

16 (a) Informant Edward A. Thompson

(b) Address 1826 Druid Hill Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)

(c) Cemetery or crematory Calvary Cemetery

Location Norfolk Va

18 (a) Funeral director Walker H. Holland

(b) Address 1631 Druid Hill Ave

19 (a) SEP 21 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1946, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1946, to 9-20 1946, and that I last saw her alive on 9-20 1946.

Immediate cause of death Intestinal Obstruction — Duration 3 days

Due to Post Operative Adhesions

Due to Operation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. B. Harris M.D. Address Provident Hosp Date signed 9-20-46

VS 150

387728 G43926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G43926 48a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4611 Elmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Feidman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Abbott Feidman
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 9-12-1881

8. AGE: Years	Months	Days	If less than one day
65	-	4	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Emanuel Endom
13. Birthplace England

MOTHER
14. Maiden Name Fanny Elfenbaum
15. Birthplace " " England

16 (a) Informant Nurse
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem.
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Filed 9-22-1946 (b) Signature of registrar Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Sept 20 1946 and that I last saw her alive on Sept 20 1946

Immediate cause of death Carcinoma — Duration

Due to Cancer cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Nov 1945 2 X
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1946 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Novak M. D.
Address Johns Hopkins Hospital Date signed 9-20-46

VS 150

G43927 G43927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Use correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3715 Liberty Heights ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora C. Friedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Morris D. 1888
Oct. 30, 1889
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 25 1862
8. AGE: Years 56 Months 10 Days 22 (7)
If less than one day: hr. min.
9. Birthplace: Austria (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business

FATHER
12. Name: Hyman Spielman
13. Birthplace: Austria

MOTHER
14. Maiden Name: Goldie Beryl
15. Birthplace: Austria

16 (a) Informant: Morris D. Friedman
(b) Address: 3715 Liberty Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 22/46 (mo.) (day) (yr.)
(c) Cemetery or crematory: Mt Chaim Cemetery
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros.
(b) Address: 1114 - 26 W. North ave

19 9 1946 (Rec'd by registrar) (b) 2 1946 Registrar

Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1946, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1946 to Sept 21 1946, and that I last saw her alive on Sept 21 1946.

Immediate cause of death: Resp. Failure — Duration

Due to: Subarachnoid hem. — 21 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Stanley H. Jaffe
Address: [redacted] Date signed: 9/23/46 M. D.

VS 150

×

G43928 BALTIMORE CITY HEALTH DEPARTMENT ✓ G43928
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Blaine Kegarice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1917

8. AGE: Years	Months	Days	If less than one day
29	1	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business State Road Commission

FATHER
12. Name Chester B. Kegarice
13. Birthplace Lewisburg, Pa.

MOTHER
14. Maiden Name Mary Lillian Ring
15. Birthplace Halethorpe, Md.

16 (a) Informant Mrs. M. L. McKay
(b) Address 3301 W. Mulberry St.

17 (a) Burial (b) Date thereof Sept. 24, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lamotte
(b) Address 4510 Liberty Heights Ave.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

SEP 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1946 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1946 to Sept 20 1946 and that I last saw him alive on Sept 20 1946

Immediate cause of death: Essential Hypertension — Duration
Hypertension
Cardio vascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Susswald M.D.
M. D.

Address 1429 W. Fayette St. Date signed Sept 21, 1946

X

G43929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G43929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md General Hosp
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2934-St Paul- Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2934 St Paul # 18.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Faust

3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife James A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1902

8. AGE: Years 44 | Months 2 | Days 22. | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm F. Berins
13. Birthplace Virginia

MOTHER
14. Maiden Name Nellie Bolthis
15. Birthplace Va.

16 (a) Informant James A. Foust Jr
(b) Address 2934 St Paul St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/22/46 (month) (day) (year)
(c) Cemetery or crematory Round Top Cem
Location West Virginia

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul street

19 (a) Date received 9 22 1946 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22nd 1946, at 4 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29/1946 to 9/22/1946, and that I last saw her alive on 9/22/1946.

Immediate cause of death	Duration
Caquexia	
Due to Generalized Carcinomatosis	53 days
Due to Ca of Liver.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. C. Gonzalez M.D.
Address Maryland G. Hosp. Date signed 9/22/46

G43930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120B

G43930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 W Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Feit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sylvan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years: 21 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Max Cohen
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Sarah
15. Birthplace: Russia

16 (a) Informant: Sylvan Feit
(b) Address: 1402 W Balto St

17 (a) Burial (b) Date thereof 9-22-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: United Hebrew
Location: Washington Boulevard

18 (a) Funeral director: Jacob Levine Inc
(b) Address: 1402 E Balto St

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19, 1946 at 0558 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/ 1946 to 9/19 1946, and that I last saw h[illegible] alive on 9/19 1946.

Immediate cause of death: Overwhelming tuberculosis — Duration:

Due to: Chronic ulcerative colitis — 4 Yrs 9 months

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Samuel D Zalis M.D.
Address: Sinai Hospital Date signed 9/19/46

VS 150

G43931 G43931

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2655 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jenna Tatelbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jahn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mortel
13. Birthplace Russia

MOTHER
14. Maiden Name Haynah
15. Birthplace Russia

16 (a) Informant Max Tatelbaum
(b) Address 3715 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-46 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Balto St

19 (a) (b)
(Signature of registrar) Registrar

9 22 1946 Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1946, at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1946, to Sept 21 1946, and that I last saw h[illegible] alive on Sept 21 1946.

Immediate cause of death: Heart Failure — Duration:

Due to: Intracardiac Heart Disease — 5 yrs

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel V. Tompkins M. D.
Address 3431 Park Heights Ave Date signed Sept 23 1946

G43932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G43932 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Patterson Pk. Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Karol Studzinski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances Studzinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1885

8. AGE: Years	Months	Days	If less than one day
61	6	12	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Pressor
11. Industry or business

FATHER
12. Name Thomas Studzinski
13. Birthplace Poland

MOTHER
14. Maiden Name Paulina Merecki
15. Birthplace Poland

16 (a) Informant Mrs. Frances Studzinski
(b) Address 414 S. Patterson Park Ave

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) SEP 22 1946 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Sept. 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Sept 1946 to 19 Sept 1946 and that I last saw him alive on 18 Sept 1946.

	Duration
Immediate cause of death Pulmonary Embolus	—
Due to Cancer of Splenic Flexure	2 Mos.
Due to	
Other Conditions Bronchial Asthma. (Include pregnancy within 3 months of death)	

Date of operation 14 Sept. 1946
Major findings of operation: Cancer of Splenic Flexure
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas M. Hutchins M.D.
Address South Balto. Hosp. Date signed 19 Sept. 1946

X

G43933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43933 Registered No.

124 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 4 Castle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 E. Eastlett (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Gustav Schneesloder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/1871

8. AGE: Years 75 | Months 6 | Days 17 | If less than one day hr. — min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Samuel Schneesloder
13. Birthplace Germany

MOTHER 14. Maiden Name Edna Martin
15. Birthplace Germany

16 (a) Informant Mrs Mamie Doods
(b) Address 745 McCabe Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md

18 (a) Funeral director Heath Brantley
(b) Address 900 E. Chester St

SEP 22 1946 Died (Date received by registrar) Lillington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946, at 6 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Sept 20 1946, and that I last saw him alive on Sept 20 1946

Immediate cause of death	Duration
Coronary Thrombosis	9/20/46
Due to Chr Myocarditis	5/46
Due to Cirrhosis of Liver	5/46
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J Roane M.D.
Address 901 4 Kenwood Ave Date signed 9/20/46

G43934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G43934

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3731 Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3731 Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Estelle Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard P. Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 27, 1897

8. AGE: Years 49 | Months 2 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Oscar Jurey
13. Birthplace Virginia

MOTHER
14. Maiden Name Katie E. Holtz
15. Birthplace Baltimore Md

16 (a) Informant Howard P. Marshall
(b) Address 3731 Garrison Ave.

17 (a) Burial (b) Date thereof Sept 23, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location Frederick Ave Baltimore

18 (a) Funeral director Lowry Byers
(b) Address 3005 Fourth Heights Ave

19 (a) (b)
(Date received by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946 at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1946 to Sept 19 1946 and that I last saw her alive on Sept 19 1946.

Immediate cause of death: Bronchio-genic Carcinoma Congd — Duration: Unknown

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Emsor M. D.

Address 7201 York Rd. Date signed 9-20-46

Dalton Md

G43935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G43935 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 E. HOFFMAN ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME MARGARET F. WEHR

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED

6 (b) Name of husband or wife ALBERT WEHR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 11, 1887

8. AGE: Years	Months	Days	If less than one day
58	10	4 10	hr. min.

9. Birthplace MARYLAND.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name JOHN LAWSON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY WILSON
15. Birthplace MARYLAND

16 (a) Informant Virginia Lawson
(b) Address 1800 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Avenue

18 (a) Funeral director John C. Miller & Son.
(b) Address 2465 E. Oliver Street
(c) Date received by registrar SEP 23 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21-46 1946, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 28 1946, to SEPT. 21 1946, and that I last saw HER alive on 9-21 1946.

Immediate cause of death	Duration
PERIPHERAL VASCULAR COLLAPSE.	
Due to GENERAL AND DIFFUSE PERITONITIS.	
Due to PERFORATION OF MALIGNANCY OF BOWEL.	
Other Conditions PELVIC ABSCESS, FECAL FISTULAE Rt. lumbar and upper gluteal	

(Include pregnancy within 3 months of death)
Date of operation AUGUST 28, 1946
Major findings of operation: SEPT. 11, 1946
OBSTRUCTION OF BOWEL AT SIGMOID.
of autopsy: MALIGNANCY SIGMOID

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jamed A. Roberts M. D.
Address Mercy Hospital Date signed 9-24-46

VS 150

G43936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G43936

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Doyle

3 (b) If veteran, name war: World War I + II
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W.

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1899

8. AGE: Years	Months	Days	If less than one day
46	11 29	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Meat Cutter
11. Industry or business

FATHER
12. Name Lawrence R Doyle
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Crumbine
15. Birthplace Md.

16 (a) Informant Arthur L Doyle
(b) Address 2143 N Fulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch Cem.
Location Carroll Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 1317 St Paul St

SEP 23 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21, 1946, at 2 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Intracranial hemorrhage

Due to

Other Conditions Fractured ribs, nose, and jaw.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 4/2
(a) Date of injury 9-21-46 at 1:30 A.M.
(b) Where did injury occur? S.E. Cor. Baltimore & Greene Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9-21-46

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G4:3937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3026 West Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 West Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie C Dorsey

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Michael J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1861

8. AGE: Years	Months	Days	If less than one day
85	3	27	hr. min.

9. Birthplace Baltimore County
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Kyne
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Feeney
15. Birthplace Ireland

16 (a) Informant Royal P Dorsey
(b) Address 3026 W Garrison Ave, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St., Balto., Md.

19 SEP 23 1946 (Date rec'd by registrar) (Signature of Registrar)

SEP 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946, at 8:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946, to Sept 20 1946 and that I last saw h[er] alive on Sept 20 1946.

Immediate cause of death: Uraemic Coma — Duration 2 dys

Due to Artery Sclerosis, Anemia

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Miller

Address 5276 Park Hgts. Date signed Sept 21 '46

G43938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G43938

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Barclay
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Barclay (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leo B. Scalley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10. 1882

8. AGE: Years	Months	Days	If less than one day
64	8	11	hr. min.

9. Birthplace Texas Balto Co. (Town, county, and state)

10. Usual Occupation Accountant.

11. Industry or business Unemployed

MOTHER FATHER

12. Name Malachi Scalley

13. Birthplace Ireland

14. Maiden Name Katie Duke

15. Birthplace Md

16 (a) Informant Catherine Scalley

(b) Address Loch Raven R F D 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St Paul St

19 SEP 23 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/46 19 at 4:30 A M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Weeks M.D. Medical Examiner.

Date signed 9/22/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1222

G43939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Finnegan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Singe

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1862

8. AGE: Years	Months	Days	If less than one day
84	4	17	hr. min.

9. Birthplace New York, N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Finnegan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Fagan
15. Birthplace Ireland

16 (a) Informant MRS. HELEN LONG
(b) Address 614 E. 33RD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREEN MOUNT AVE & 22ND ST.

19 (a) (Date received by Registrar) SEP 23 1946 (b) Registrar Livingston Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1946 at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1946 to 9/20 1946 and that I last saw her alive on 9/20 1946

Immediate cause of death	Duration
respiratory failure	
Due to intestinal obstruction	
Due to volvulus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/20/46

Major findings of operation: herniated left bladder

of autopsy: wall from left kidney

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. J. Gaubert Jr. M.D.
Address St. Agnes Hosp. Date signed 9/20/46

643940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 643940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1340 Cleveland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Molock

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1887

8. AGE: Years	Months	Days	If less than one day
59	1	14	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Molock
13. Birthplace Md.

MOTHER
14. Maiden Name Liza Mills
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave

19 (a) [illegible] Washington Hill, Md.
(Date rec'd by registrar) (Registrar)

SEP. 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946, at 7:15pm

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1946, to Sept. 19 1946, and that I last saw h[im] alive on Sept 19 1946.

Immediate cause of death	Duration
(a) Cerebro - Vascular accident	
Due to Hypertensive C-V Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert R. Fowler
Address Balto City Hosps Date signed 9-17-46

G43941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G43941 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1059 W. Lexington St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1059 W Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Bernice Gertrude Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Melvin

6 (c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1914

8. AGE: Years: 32 | Months: 1 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Waitress

11. Industry or business

FATHER
12. Name: Bernard Roden
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Gertrude
15. Birthplace: Baltimore, Md.

16 (a) Informant: Marcellina Price (Mother in law)
(b) Address: 707 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/23/46 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem'l. Pk.
Location: Balto. County, Md.

18 (a) Funeral director: Charles B. Cooper
(b) Address: 510-512 N. Carrollton Ave

19 (a) (Date received by registrar) (b) Registrar

SEP 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19, 1946 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage, Spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Wilson M.D.
Medical Examiner.
Date signed 9 20 46

G43942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 46E

Registered No. G43942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 Light St.
(c) Hospital or institution: So. Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Heller

3 (b) If veteran, name war ****
3 (c) Social Security Account No. *****

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife Fredrick W Heller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1864

8. AGE: Years 82 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harriberg
13. Birthplace France.

MOTHER
14. Maiden Name Margaret Druppe
15. Birthplace Pa.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date received by registrar) (b) Registrar
SEP. 23 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21-46 19 4 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 19 46 to 9-21 19 46, and that I last saw her alive on 9-21 19 46.

Immediate cause of death: Carcinoma of sigmoid with metastasis to liver

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 120 Light St. Date signed 9-21-46

G43943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G43943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale Home
(c) Hospital or institution:
Belvedare Ave & Greenspring Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5038 Queensbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE ROSENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Leather Bussiness

FATHER
12. Name Israel Rosenberg
13. Birthplace Poland

MOTHER
14. Maiden Name Sonia ?
15. Birthplace Poland

16 (a) Informant Sarah Rosenberg
(b) Address 5038 Queensbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Cemetery
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W Forth Ave

19 (a) Filed SEP 23 1946 (b) Registrar Huntington Williams M.D.

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1946 at 4.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1946 to 9-22 1946 and that I last saw h alive on 9-22 1946

Immediate cause of death Tumor of spinal cord

Due to

Due to

Other Conditions Cystopyelitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 9-22-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G43944 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3812 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Alverta Grace Roboust

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Frederick A. Roboust

6 (c) If widow give age years

7. Birth date of deceased (mo., day, yr.) March 6 1882

8. AGE: Years 64 | Months 6 | Days 15 | If less than one day hrs. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Daniel Smith
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Walker
15. Birthplace Maryland

16 (a) Informant Harry F. Roboust
(b) Address 3416 Chestnut Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27-1946 (month) (day) (year)

(c) Cemetery or crematory St Marys Cranberry
Location Baltimore, Maryland

18 (a) Funeral director Dyer Funeral Home
(b) Address 3631 Falls Road

19 (Date rec'd by registrar) SEP 23 1946 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21- 1946, at 3:45 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 5 1946, to Sept 21 1946, and that I last saw h[illegible] alive on Sept 19 1946

Immediate cause of death: Coronary Occlusion — Duration sudden

Due to: Chronic Valvular Heart disease — Duration 5-6 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Dreckman

Address R+6 W 36 Pt-81 Date signed 9/27/46.

G43945

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH √477

Registered No. G43945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. MARINE Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State LA. (b) County
(c) City or town NEW ORLEANS (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 MAGAZINE ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No. 418-17-3662

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife MERCIDES Kelly
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) MAY 19 1892

8. AGE: Years	Months	Days	If less than one day
49	4	3	hr. min.

9. Birthplace PLAINFIELD, N. J. (Town, county, and state)
10. Usual Occupation MERCHANT SEAMAN.
11. Industry or business

FATHER
12. Name Joseph Kelly
13. Birthplace CORK, IRELAND

MOTHER
14. Maiden Name PAULINE DAVEY
15. Birthplace PLAINFIELD, N.J.

16 (a) Informant MARINE HOSPITAL
(b) Address BALTIMORE, MARYLAND

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk, Va.

18 (a) Funeral director Miller & Aeworth
(b) Address 1005 N. Baltimore St.

19 (a) (Date received by registrar) SEP 23 1946 Huntington Williams (Registrar) (b) Filed

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1946, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Sept 22 1946 and that I last saw him alive on Sept 22 1946

Immediate cause of death	Duration
MYOCARDIAL INSUFFICIENCY.	
Due to CANCER OF LUNG	1 YEAR
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation APR. 25, 1946
Major findings of operation: INOPERABLE CANCER OF RT. LUNG
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joe M. Christian M. D.
U.S. MARINE Hospital Date signed 9/22/46

VS 150

G43946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G43946 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 739 Dolphin Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 739 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK CHISLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-8581

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1883

8. AGE: Years	Months	Days	If less than one day
63	6 9	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Night Porter
11. Industry or business

FATHER
12. Name John F. Chisley
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Farrell
15. Birthplace Md.

16 (a) Informant Mr. Louis A. Chisley
(b) Address 739 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

SEP 23 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1946, to 9-20 1946, and that I last saw h alive on 9-20 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 9

Due to

Due to

Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Chisley M. D.
Address 739 Dolphin Date signed 9-24-46

G43947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G43947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 Pierce Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Pierce Street
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME JANIE GENEVIE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Oscar L. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1900

8. AGE: Years	Months	Days	If less than one day
46	1	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Chambers
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Veales
15. Birthplace Va.

16 (a) Informant Mr. Oscar L. Williams
(b) Address 939 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 SEP 23 Washington Williams, Mgr

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 21, 1946 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1946 to 9-21, 1946 and that I last saw h alive on 9-20- 1946

Immediate cause of death Hypertensive Heart. Duration 6 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Page M.D.
Address 1816 N. Monroe St. (17) Date signed 9-23-46

X

G43948 (over) BALTIMORE CITY HEALTH DEPARTMENT G43948

CERTIFICATE OF DEATH 160c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 Harford Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Fell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9/21/46

8. AGE: Years	Months	Days	If less than one day
			1 hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nicholas J Fell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Frances Keenan
15. Birthplace Baltimore, Md.

16 (a) Informant Nicholas J Fell
(b) Address 1737 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director George J Ruth Inc
(b) Address 1725 Harford Ave

19 (a) ____ (b) ____ Registrar
(Date rec'd by registrar)
SEP 23 1946 Huntington Williams, M.D.
150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/46 19 at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1946 to 9/21 1946 and that I last saw him alive on 9/21 1946.

Immediate cause of death Immaturity

Due to Abortion - Incomplete

Due to Separation of Placenta

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. P. Cruikshank
Address Mercy Hospital Date signed 9/21/46 M.D.

G43949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1186a

Registered No. G43949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 W. Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Elmore

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or wife Upton T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 - 1860

8. AGE: Years	Months	Days	If less than one day
86	5	—	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name John Wilson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ann Murphy
15. Birthplace —

16 (a) Informant William J. Elmore
(b) Address 211 W. McComas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Ann's
Location Baltimore Md.

18 (a) Funeral director Flynn & Flaming
(b) Address 1412 Light St

19 (a) SEP 23 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/1946 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3/1946 to 9/26/1946.
and that I last saw h alive on 19
Immediate cause of death Coronary thrombosis — Duration 1 hour
Due to arteriosclerosis — years
Due to senility —
Other Conditions Fracture right femur 16 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 5/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9-6-46 at ? M
(c) Where did injury occur? 12 W. Hamburg St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? Home While at work? —
(Specify type of place)
(e) Means of injury Slipped & fell to floor

23. Signature Isaac Rule M. D.
Address 1st & Cleaves Date signed

VS 150

For Bur. Vital Statistics, by Howard J. Morgan, M.D. 9/23/46 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G43950

G43950

52 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 878½ W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 878½ W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Stengel

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1860

8. AGE: Years	Months	Days	If less than one day
86	1	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Adam Stengel
13. Birthplace Germany

MOTHER
14. Maiden Name Ursala Veith
15. Birthplace Germany

16 (a) Informant John Stengel, Jr.
(b) Address 878½ W. Lombard St.

17 (a) Burial (b) Date thereof Sept. 24, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Durward Q. Covington
(b) Address 21 W. 25th St.

SEP 23 1946 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1946 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Sept 20 1946.
and that I last saw her alive on Sept 20 1946

Immediate cause of death: Carcinoma of Bladder — Duration ?

Due to

Due to

Other Conditions Chr arthritis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl P. Rostberg M. D.
Address 1326 W Lombard St Date signed 9/24/46

VS 150

G43951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

G43951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1641 No Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give County)
(d) Street No. 1641 No Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie Steinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Rose Steinberg
(b) Address 1641 No Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale Location Philp Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1495 Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1946, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Sept 22 1946 and that I last saw her alive on 9-22 - 1946.

Immediate cause of death	Duration
Generalized arterio-sclerosis	15 yrs
Due to Terminal Broncho-pneumonia	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack Cohen
Address 1804 Eutaw Place Date signed 9/23/46 M. D.

VS 1 SEP 23 1946

Huntington Williams M.D.

G43952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G43952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Spaulding Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Stark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Austria

MOTHER
14. Maiden Name unknown
15. Birthplace Austria

16 (a) Informant Albert Stark
(b) Address 3603 Glen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location East Baltimore Pk

18 (a) Funeral director Jack Levin Inc
(b) Address 1434 E Balto St

19 (a) (Date rec'd by public reg.) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1946 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1946 to 9/22 1946 and that I last saw h[illegible] alive on 9/22 1946

Immediate cause of death Cerebro [illegible] was result of accident

Duration

Due to

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Heinz Beissinger M. D.

Address Sinai Hospital Date signed 9/22/46

55 P 28 1946

S.U.50

G13953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G13953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Fayette
(c) Hospital or institution:
Univ. Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Mt Royal Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Haines, Herman F.

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-8179

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widowed

6 (b) Name of husband or wife Mooney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Carroll Co - Md (Town, county and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name unknown
15. Birthplace Maryland

16 (a) Informant Loy F. Haines
(b) Address 2314 Linden Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-46 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem
Location Westminster Md

18 (a) Funeral director Jack Lewis Inc
(b) Address 1496 E Balto St

19 (a) (b)

SEP 23 1946 Registrar Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/46 1946, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946, to Sept. 20 1946, and that I last saw him alive on Sept. 20 1946.

Immediate cause of death respiratory failure — **Duration**

Due to cachexia & debility

Due to Ca. of Stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/12/46

Major findings of operation: pyloric obstruction.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Lyerton M.D.

Address Univ. Hosp. Date signed 9/20/46 M. D.

G43954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Walther Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Trautner, Mrs. Margaret Elizabeth.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr. George Trautner.

6 (c) If alive, give age: 7 years

7. Birth date of deceased (mo., day, yr.) June 13, 1882

8. AGE: Years 64 | Months 3 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore.
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business Housework.

FATHER
12. Name Vogel, George.
13. Birthplace Germany.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany.

16 (a) Informant Mr. George Trautner
(b) Address 4618 Walther Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) ..... (Date rec'd by registrar) (b) Thomas Worthington Williams, M.D. Registrar

VS 1937 SEP 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1946, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18, 1946, to Sept 20 1946, and that I last saw h[illegible] alive on Sept 19 1946.

Immediate cause of death: Cerebral hemorrhage — Duration: 3 days.

Due to Hypertensive cardiovascular disease. — 10 yrs.

Due to Arteriosclerosis, general. — 1 / 15 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Bachman M.D.
Address Church Home & Hospital Date signed Sept 20, 1946.

G43955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G43955 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Elliott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1865

8. AGE: Years	Months	Days	If less than one day
81	0	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John P. Williams
13. Birthplace England

MOTHER
14. Maiden Name Ann Williams
15. Birthplace England

16 (a) Informant F. Williams
(b) Address 428 Elrino St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) Date received by Local Registrar SEP 23 1946 (b) Registered by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946 at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1946, to Sept 20 1946, and that I last saw her alive on Sept 20 1946.

Immediate cause of death

Carcinoma of Uterus — Duration 2-15-46

Due to Cervix

Due to None

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Eschenmark M. D.

Address 842 S. Eden Ave Date signed 9-21-46

G43956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G43956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 Jackson Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Lifeboard

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Jackson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Dobkin.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham -
13. Birthplace Russia

MOTHER
14. Maiden Name -
15. Birthplace Russia

16 (a) Informant Hyman Rabinowitz
(b) Address 124 Jackson Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1139 E. Balti St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

SEP 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1946 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1st 1945 to Sept 23 1946 and that I last saw her alive on Sept 23 1946.

Immediate cause of death — Duration

Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Ephraim, M.D.
Address 443 E. 25th Date signed Sept. 23, 1946

X

G43957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G43957 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KLAAK

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 220-05-8362

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jane A. Klaak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1873

8. AGE: Years	Months	Days	If less than one day
73	1	19	hr. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual Occupation: Barber
11. Industry or business: Emerson Hotel

FATHER
12. Name: Frank Klaak
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Jane A. Klaak
(b) Address: 2633 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)
(c) Cemetery or crematory: WOODLAWN CEM.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: [illegible] Williams, M.D.
(c) (Date rec'd by registrar) SEP 23 1946 (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21- 1946, at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Mullen M.D.
Medical Examiner.
Date signed 9-21-46

VS 151

Please write the causes of death clearly and legibly. Physicians: please write exact age in especially important.

G43958 G43958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √467

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Windsor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Ellington Ridgely

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	212-09-9214	M	W	married

6 (b) Name of husband or wife Hazel Satterfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1893

8. AGE: Years	Months	Days	If less than one day
53	6	16	hr. min.

9. Birthplace Near Fork, Md. (Town, county, and state)
10. Usual Occupation Collection Mgr.
11. Industry or business Hub Co.

FATHER
12. Name Walter B. Ridgely
13. Birthplace Prince Georges Co., Md.

MOTHER
14. Maiden Name Blanche M. Hurtt
15. Birthplace Upper Falls, Md.

16 (a) Informant Mrs. Hazel Satterfield
(b) Address 2307 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)
(c) Cemetery or crematory Old Oakland Cem.
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (Registrar)

SEP 23 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1946 at 12 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946 to Sept 21 1946 and that I last saw h[illegible] alive on Sept 21 1946

Immediate cause of death Uremia — Duration

Due to Ureteral obstruction
Fibroids

Due to Intestinal obstruction
Carcinoma of Rectum

Other Conditions Multiple perforated duodenal ulcers
(Include pregnancy within 3 months of death)

Date of operation Sept. 18, 1946

Major findings of operations: Carcinoma of rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place) While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. McCurdy M. D.
Address University Hosp. Date signed 9-21-46

X

G43959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G43959 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4103 Springdale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HARRY DITTMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-07-8353

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Blanche H. Dittman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1877

8. AGE: Years	Months	Days	If less than one day
69	8	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Vice President
11. Industry or business U. S. F. & G. Co.

FATHER
12. Name John Henry Dittman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Alice DeMoff
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Blanche H. Dittman
(b) Address 4103 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1946, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Sept 21 1946 and that I last saw h alive on Sept 21 1946.

Immediate cause of death	Duration: Interval
Coronary Thrombosis	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Simmons M. D.
Address 4509 Liberty Rd Date signed Sept 23

VS 150

X

G43960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G43960 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

1352

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 1907 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M. WAGNER

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. R. Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1879

8. AGE: Years 67 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation --

11. Industry or business --

FATHER
12. Name August M. Meukirch
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Kayser
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Robert E. Wagner
(b) Address 1907 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

1946 (Date rec'd by registrar) (b) Registrar

VS 150 Transcription for Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1946, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 22 1946 and that I last saw deceased alive on Sept 22 1946

Immediate cause of death
Carcinomas of the Descending Colon & Metastasis. — Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 6 mos?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck
Address 1002 E. 23rd St Date signed Sept 23-46

X

G43961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G43961

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 6 wks.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Balto.
(c) City or town Dundalk Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7814 York way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gilbert Wagner Parker (GILBERT WAGNER PARKER)
3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9 1946
8. AGE: Years — Months 1 Days 11 If less than one day hr. min.
9. Birthplace Dundalk, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Hubert Parker
13. Birthplace N. Carolina
MOTHER 14. Maiden Name Aline Wagner
15. Birthplace N. Carolina
16 (a) Informant Mother
(b) Address 7814 York way Dundalk

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 23. 1946 (month) (day) (year)
(c) Cemetery or crematory Conover Cemetery
Location Conover North Carolina
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address BALTIMORE, MD.
23 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/46 19 , at 8:05 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1946 to 9/20 1946.
and that I last saw him alive on 9/20 1946.

Immediate cause of death	Duration
Respiratory failure & cardiac failure	
Due to Resp. obstruction, emphysema, pneumonia	
Due to Bi-lateral Harelip	
Other Conditions Hare lip cleft	

(Include pregnancy within 3 months of death)

Date of operation 9/20/46
Major findings of operation Repair of hare lip cleft palate
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph D'Antoni M. D.
Address Date signed

VS 150

G43962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43962 Registered No. 170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 D. Street, S.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Roland Vogelgesang

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha A.

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) April 3, 1896

8. AGE: Years 50 | Months 5 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (town, county, and state)

10. Usual Occupation: Ship fitter Spl. leading man
11. Industry or business: U. S. Coast Guard, Curtis Bay

FATHER
12. Name John Vogelgesang
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ida ?
15. Birthplace Scotland

16 (a) Informant Mrs. Bertha A. Vogelgesang
(b) Address 312 D. S.W. Glen Burnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25 1946 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md.

18 (a) Funeral director Thomas W. Doughty
(b) Address Glen Burnie Md.

SEP 23 1946 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1946, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Intracranial hemorrhage
Laceration of brain.

Other Conditions Fractured ribs (1st and 2nd)
Fractured left tibia and fibula
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-21-46 at 9:30 P.M.
(b) Where did injury occur? Ritchie Highway, ½ mi. north of Glen Burnie
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto

23. Signature George E. Mahrill M.D. Medical Examiner.
Date signed 9/23/46

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FL - 643963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43963 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Inner Circle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annal [illegible] Whitley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1909

8. AGE: Years	Months	Days	If less than one day
37 [illegible]	1	28	hr. min.

9. Birthplace Md.
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Andrew Rutowski (D)
13. Birthplace Poland

MOTHER
14. Maiden Name Mary (D)
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Md

18 (a) Funeral director Thomas J. Kenny Inc
(b) Address Hollins + Gilmor Sts

19 (a) Date received by registrar Huntington Williams, M.D. registrar

SEP 23 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1946, at 2:18 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1946 to Sept. 21 1946 and that I last saw her alive on Sept. 20 1946.

Immediate cause of death Pulmonary Tuberculosis, Far advanced — Duration 11 yr.

Due to

Due to

Other Conditions Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 9-21-46

(over)

G43964

501104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G43964 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jamor John Nicstubicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 - 2 - 1910

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Henry Nicstubicz

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Josephine Skoop.

MOTHER 15. Birthplace Md

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or Removal) (b) Date thereof Sept 24-46 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location City

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 2007 Eastern Ave

23 1946 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 20 1946 at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept - 19 1946 to Sept - 20 1946 and that I last saw him alive on Sept - 20 1946.

Immediate cause of death: Pneumonia, lobar — Duration: circum 2 weeks

Due to: Pneumococci

Due to:

Other Conditions: Cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Wagley M. D.

Address Johns Hopkins Hosp. Date signed Sept. 24 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Burial Certificate
G43965 / B-65095 (65095)
Under Coroner's Jurisdiction

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43965 Registered No. 160c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Cranston Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Richards Gilliece

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-46

8. AGE: Years	Months	Days	If less than one day
--	--	--	22 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Owen James Gilliece
13. Birthplace Paton Pennsylvania

MOTHER
14. Maiden Name Helen Winifred Null
15. Birthplace Brunswick Md.

16 (a) Informant Mr. Owen James Gilliece
(b) Address 3901 Cranston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) SEP 23 1946 (b) Huntington Whitmore, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23-1946 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1946, to 9-23 1946, and that I last saw him alive on 9-23 1946.

Immediate cause of death: Cardio-respiratory failure — Duration:
Due to: Prematurity (28 week)
Due to: Caesarean section for Placenta previa
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp, Balto Date signed

X

398748
G43966

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G43966 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Fisher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/98

8. AGE: Years	Months	Days	If less than one day
47 48	11	27	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Kitchen worker
11. Industry or business

FATHER
12. Name Samuel Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Dobson
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location A.A. Md

18 (a) Funeral director Isaac L Brauford
(b) Address 1018 W Montgomery St

19 (a) ~~SEP 23 1946~~ Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1946 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1946 to Sept 18 1946, and that I last saw her alive on Sept 18 1946.

Immediate cause of death	Duration
Carcinoma Rt. breast metastases to pleura, pericardium, regional lymph nodes	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature O. T. Davis
Address Johns Hopkins Hospital Date signed 9/17/46

FL - 104580 G43967 BALTIMORE CITY HEALTH DEPARTMENT X G43967
CERTIFICATE OF DEATH 30E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Havre de Grace, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Bullock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1880

8. AGE: Years	Months	Days	If less than one day
65	9	15	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Crane Operator

11. Industry or business Curtis Bay

FATHER
12. Name Isaac Bullock
13. Birthplace Penna

MOTHER
14. Maiden Name Anna Walters
15. Birthplace Penna

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24-46 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace Md

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace Md

SEP 23 1946 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1946, at 5:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1946 to Sept. 21 1946 and that I last saw h. alive on Sept. 21 1946.

Immediate cause of death: Rupture of Aortic Aneurysm into Esophagus — Duration: Immediate death
Due to: Probable Syphilitic
Due to: Cardiovascular Disease — Duration: Unknown

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mannion M. Long M. D.
Address Baltimore City Hospital Date signed 9-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G43968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1144 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Carothers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie E. Carothers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18th 1884

8. AGE: Years 62 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired Watchman
11. Industry or business W. T. Cowan

FATHER
12. Name Joseph Carothers
13. Birthplace Phila, Pa.

MOTHER
14. Maiden Name unknown
15. Birthplace Philadelphia Pa.

16 (a) Informant Mrs Hilda D. Groth
(b) Address 1630 Sexton St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/25/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location 2930 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901 & 03 Hollins St.

19 (a) (Date received by Registrar) (b) Registrar
SEP 23 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22nd 1946 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Sept 22 1946 and that I last saw h[illegible]ive on Sept 22 1946.

Immediate cause of death: Cerebral Thrombosis — Duration 1 day

Due to: Hypertension Cardio Vascular Disease — Duration 4 yrs

Due to: — Duration

Other Conditions: Hemiplegia, left — Duration 3 yrs.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Unbek Jr
Address 1227 Wash. Blvd Date signed Sept 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G43969 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Fonthill (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary L. Raley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-1872

8. AGE: Years	Months	Days	If less than one day
74	6	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Penrod Benj. F. Docker
13. Birthplace Md

MOTHER
14. Maiden Name Penrod Eliz. Booth
15. Birthplace Md

16 (a) Informant James S. Raley
(b) Address 405 Font Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Harry R. Wittle
(b) Address 410 E. Edmondson Ave.

19 (a) (Date rec'd by registrar) (b)

VS 1 SEP 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1946 at 9.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1946 to 9/22 1946 and that I last saw her alive on 9/22 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic cardiovascular heart disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Lincoln M. D.
Address St. Agnes Hospital Date signed 9/23/46

G43970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G43970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geneva Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1891.

8. AGE: Years 55 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph T. Saunders
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah R. Hendricks
15. Birthplace Md.

16 (a) Informant: Mrs. Victor P. Hallwig
(b) Address 721 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24/46 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Lutzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 SEP 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1946 at 12 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1946 to 9/21 1946 and that I last saw h[illegible] alive on 9/21 1946.

Immediate cause of death acute myocardial failure — Duration

Due to hypertensive heart-disorder and scarie

Due to Typhoid Fiebris

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Scheye M. D.
Address 3921 Edmondson Date signed 9/24/46

H. W. Scheye

G43971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 109 B

Registered No. G43971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Shipley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1866

8. AGE: Years	Months	Days	If less than one day
79	11	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Bradley Shipley
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ford
15. Birthplace Md.

16 (a) Informant Mrs. Henry Meyer
(b) Address 2706 Grander Ave?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-46 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Mt. Airy, Maryland.

18 (a) Funeral director C. M. Wentz
(b) Address Winfield, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1946, to Sept 20 1946, and that I last saw her alive on Sept. 20 1946.

Immediate cause of death Pneumonia
& overwhelming Toxicity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Briggs, M.D. M. D.
Address Union Hosp. Date signed 9-21-46

X

G43972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓497

Registered No. G43972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 Hayward Ave (If rural, give location)
(e) Citizen of foreign country? Haymarket (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Mister Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/80

8. AGE: Years	Months	Days	If less than one day
65	9	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name George T. Mister
13. Birthplace Maryland.

MOTHER 14. Maiden Name Yeakenowe
15. Birthplace Yeakenowe.

16 (a) Informant George T. Mister Jr.
(b) Address 2807 Emerald Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location Friendship Md

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Eastern Ave

19 (a) SEP 23 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18/46 to 9/21/46.
and that I last saw h I Malive on 9/20 19

Immediate cause of death Cardio Respiratory Failure — Duration

Due to Carcinoma of Lung

Due to Squamous cell Carcinoma of 4 toe left foot

Other Conditions Diabetes & Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Tierney M. D.
Address St. Joseph's Hosp. Date signed 9/24/46

X

VS 150

G43973

BALTIMORE CITY HEALTH DEPARTMENT

TB. G43973 104587

CERTIFICATE OF DEATH 13B

Registered No. G43973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 2618
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Leverton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (E) Albert Marski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21/1904

8. AGE: Years	Months	Days	If less than one day
42	5	0	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Marski
13. Birthplace Maryland

MOTHER 14. Maiden Name Frances
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/46 (month) (day) (year)
(c) Cemetery or crematory H. Harkins Laws
Location O'Donnell Rd.

18 (a) Funeral director John J. Mc Donnell & Bro.
(b) Address 3000 E. Balto. St.

19 (Date rec'd by registrar SEP 23 1946) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21/1946 19 , at 5.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18/ 1946 to Sept 21 1946 and that I last saw him alive on Sept 21/ 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary tuberculosis & pleural effusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B.C.H. Date signed 9/22/46

X

G43974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G43974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairland & Green St.
(c) Hospital or institution:
University Hospital. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Ocenogle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	married.

6 (b) Name of husband or wife Elizabeth.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29 - 1888

8. AGE: Years	Months	Days	If less than one day
58	6	22	hr. min.

9. Birthplace Indiana
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John H. Ocenogle
13. Birthplace Indiana

MOTHER 14. Maiden Name Isabelle Kenneth
15. Birthplace Kentucky

16 (a) Informant Mary E. Ocenogle
(b) Address 10 S Highland Av

17 (a) Burial (b) Date thereof Sept 25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John G Moran
(b) Address 3600 Eastern Ave

SEP 23 1946 (Signature of registrar) Huntington Mills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1946, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946 to Sept 21 1946, and that I last saw h/ she alive on Sept 20 1946

Immediate cause of death Cardiac failure — Duration

Due to Toxemia

Due to Carcinoma of Colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 1946

Major findings of operation: Carcinoma of ascend. colon

of autopsy: " " "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J A Vaughan Jr M.D.
Address Medical & Surgical Date signed 9-22-46

G43975 G43975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1254 Woodbourne
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1254 Woodbourne (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Allen Beetham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ida Covert Beetham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1859

8. AGE: Years	Months	Days	If less than one day
86	10	14	hr. min.

9. Birthplace Brooklyn, N. Y. (town, county, and state)
10. Usual Occupation Retired 25 years
11. Industry or business

FATHER
12. Name Thomas Beetham
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Appleyard
15. Birthplace England

16 (a) Informant Gertrude Beetham
(b) Address 1254 Woodbourne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Lyman Oak Ave.

18 (a) Funeral director John A. McMann
(b) Address 3011 E. Baltimore St.

SEP 23 1946 (a) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1946, at 7:05 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1946 to Sept 23 1946 and that I last saw h[illegible] alive on Sept. 22 1946.

Immediate cause of death	Duration
Angina Pectoris	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles B. MacMann M. D.
Address 2911 E. Baltimore St Date signed Sept 23 1946

X

G43976 ✓ G43976

AB-104375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

836

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cleveland McClary -or- Cleveland McClory

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-6604

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife (Lucy) Lucille
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1893

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	4	15		

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Prince McClary or McClary
13. Birthplace S.C.

MOTHER 14. Maiden Name Eliza Tisdeal
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory
Location Kingsville S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave
23 1946 Huntington Williams, M.D. (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1946, at 7.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1946, to 9-18 1946, and that I last saw h IM alive on 9-18- 1946

Immediate cause of death: Respiratory Failure — Duration
Due to: Cerebral Thrombosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Cerebral Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J E Robinson Jr M. D.
Address Balt. City Hosp. Date signed 9/23/46

VS 150

X

G43977 BALTIMORE CITY HEALTH DEPARTMENT ✓ G43977
CERTIFICATE OF DEATH 55E
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Fredrick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Father Gregory (Edward J Donahue)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 2 1896
8. AGE: Years 57 Months 4 Days 28 If less than one day hr. min.
9. Birthplace (City, county and state)
10. Usual Occupation C. Priest
11. Industry or business
FATHER 12. Name Dennis Donahue
13. Birthplace Mayo
MOTHER 14. Maiden Name Nora Goggin
15. Birthplace Not Known
16 (a) Informant Very Rev. Fr Agatho
(b) Address 8000 Frederick Rd Rec'd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-46 (Month) (Day) (Year)
(c) Cemetery or crematory St Jeromes Cem
Location Brighton Mass
18 (a) Funeral director Fenno & Farley
(b) Address Fulton & Fayette
19 9/24/1946 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/46 19 at 10 40 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1946 to 9-22 1946, and that I last saw him alive on 6-22 1946
Immediate cause of death: Retroperitoneal cell lymphosarcoma, inguinal region — Duration 1-2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lawrence J. Cannon M.D.
Address St. Agnes Hospital Date signed 9-23-46

V. S. 150

G43978

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G43978 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Asheville N.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Searcy

3 (b) If veteran, name war

3 (c) Social Security Account No. 246-12-3707

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1902

8. AGE: Years	Months	Days	If less than one day
43	8	20	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name William Searcy
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Tiny Mae Davis
15. Birthplace N. Carolina

16 (a) Informant deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-46 (month) (day) (year)
(c) Cemetery or crematory Riverhill Cem
Location Asheville N.C.
18 (a) Funeral director Geo. A. Talley
(b) Address Fulton & Fayette Sts
(c) (b) Huntington Williams, M.D.

SEP 27 1946 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1946, at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1946, to 9-22 1946 and that I last saw him alive on 9-22 1946.

Immediate cause of death Circ. Failure — Duration

Due to Bilateral Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James V. Minor, Jr. M. D.
Address Mercy Hosp Date signed 9-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GIVEN FREE OF CHARGE TO THE BEREAVED BY FUNERAL DIRECTORS

G43979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G43979

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp. No

(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2147 W. Lexington St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY AUGUST CONRADES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Florence T. Conrades
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 8/15/1907

8. AGE: Years	Months	Days	If less than one day
45	1	7	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation Retired Operator
11. Industry or business Balto. Transit Co.

FATHER
12. Name August Conrades
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Minnie C. Senff
15. Birthplace Richmond Va

16 (a) Informant Florence Conrades
(b) Address 2147 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1800 St. Paul St.

19 SEP 24 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/46 19 , at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19/46 19 , to 9/22/46 19 , and that I last saw h alive on 9/22/46 19 .

Immediate cause of death	Duration
respiratory failure	
Due to intracerebral hemorrhage & coma	
Due to	
Other Conditions Grant cell sarcoma of Rt. shoulder (Include pregnancy within 3 months of death)	

Date of operation Aug 22, 1946
Major findings of operation: biopsy of sarcoma
of autopsy: multiple growths on

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Mattfeldt M.D.
Address Bon Secours Date signed 9/27/46

VS 150

G43980 BCH

BALTIMORE CITY HEALTH DEPARTMENT

TB. F95703 CERTIFICATE OF DEATH 30F

Registered No. G43980

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Orchard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reginald Stewart Young

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?/?/44

8. AGE: Years	Months	Days	If less than one day
? 2	6 7	1	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Young

13. Birthplace ?

MOTHER 14. Maiden Name Mabel Diggs

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director Destroyed
(b) Address

SEP 24 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12th 1946 at 12.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 ; and that I last saw him alive on Never 19

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Congenital

Due to

Other Conditions Congenital Syphilis Retard 2 yr. Syphilis ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hedges P. Griffin M. D.
Address Baltimore City Hosp. Date signed Sept 18

Body released to the Hospital for Autopsy by Med. Exam. Dr. Lubinsky 10/1/46
To be approved by Medical Examiner. Howard A. Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43981 Over BALTIMORE CITY HEALTH DEPARTMENT X V G43981

CERTIFICATE OF DEATH 161c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
FRANKLIN SQUARE Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town PARKVILLE 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8444 Oakleigh Rd
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME RONALD LEE BURTON.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1946

8. AGE: Years	Months	Days	If less than one day
0	—	— 3	hr. min.

1day.

9. Birthplace BALTO. CITY
(Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name LEE CARROLL Burton
13. Birthplace Balto Co, Md.

MOTHER
14. Maiden Name MAGIE
15. Birthplace Balto Co, Md

16 (a) Informant Mother
(b) Address 8444 Oakleigh Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 23 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

SEP 24 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION 43

20. DATE OF DEATH Sept. 19 1946 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1946 to Sept 19 1946, and that I last saw h[illegible] alive on Sept 19 1946

Immediate cause of death Not Known — Duration not known

Due to

Due to over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Southmid
Address Franklin Sq Hosp Date signed 9/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

643982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

643982 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd ST + CALVERT
(c) Hospital or institution: UNION MEMORIAL HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 7
(e) Length of stay in Baltimore (yrs., mos., or days) 64

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County —
(b) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 440 FAWCETT ST (If rural give location)
(e) Citizen of foreign country? YES (Yes or No) If yes, name country

3 (a) FULL NAME JIMMIE HANDS

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced ?

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 1881

8. AGE: Years 64 | Months 9 | Days — | If less than one day hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation ELECTRICIAN

11. Industry or business —

FATHER 12. Name JIMMIE HANDS
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant DOMINIC ROGERS
(b) Address 440 FAWCETT ST

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 23 1946

18 (a) Funeral director Commissioner of Health.
(b) Address

19 (Date received by registrar) SEP 24 1946 (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 SEPT 1946 at 1 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 SEPT 1946 to 12 SEPT 1946 and that I last saw him alive on 12 SEPT 1946.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration A (1)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature H. Williams M.D.

Address Union Mem. Hosp Date signed 12 Sept 46

VS 150

Lib. Merrill MD X medical examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C43983 Died 9/9/46 BALTIMORE CITY HEALTH DEPARTMENT ✓ C43983

DCH 10 68202 CERTIFICATE OF DEATH 107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 74
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 N. High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Scott ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/[illegible]/46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 23 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 24 1946 (Date rec'd by registrar) (Signature) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1946, at 2 00 P.M. ✓

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Subrinake M.D.
Medical Examiner.
Date signed 9/10/46

G43984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G43984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 N Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 N Chas. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William De Bordte

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1946 at 3:50 P M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 23 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 24 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 191

21. I certify that I took charge of the remains described above, held an Autopsy / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F Hebbard M.D.
Medical Examiner.
Date signed 3 Sept 46

G43985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 167

Registered No. G43985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State West Va. (b) County Wyoming
(c) City or town Bud
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE JACKSON (Brown)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
30 ?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant unknown

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 23 1946
Commissioner of Health

18 (a) Funeral director

(b) Address

19 SEP 24 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946, at 3.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Internal + external hemorrhage from multiple stab wounds of head, ~~Due to~~ body + extremity

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-46 at 9 A. M.
(b) Where did injury occur? 386- E. 31st St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury sharp instrument-

23. Signature Howard J. Mallis M.D.
Medical Examiner.
Date signed 9-10-46

G43986

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G43986

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove State Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 23 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 24 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1946, at 12.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Right coronary thrombosis
Myocardial infarction
~~Chronic right pulmonary tuberculosis~~
Due to

Other Conditions Chronic right pulmonary tuberculosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/10/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G43987

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 E Eting St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Eting St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clemmonee Curry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Unknown

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3, 1886

8. AGE: Years	Months	Days	If less than one day
60	6	10/7	hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Nash
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mrs. Vondelear Grant
(b) Address 1805 E Eting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 24 46 (month) (day) (yr.)

(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) (b)
SEP 24 1946 Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946, at 11 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1946 to Sept 20 1946 and that I last saw h[illegible] alive on Sept 20 1946.

Immediate cause of death	Duration
Cardio Vascular Disease	Unknown
Due to Cerebral Hemorrhage	6 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature William Frey
Address 928 Penna Ave Date signed 9/25/46

X

G43988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 78 G43988

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 Penna Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Penna ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy A. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	Widowed

6 (b) Name of husband or wife Philip Bailey
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-18-1871

8. AGE: Years	Months	Days	If less than one day
75	8	4	hr. — min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business own home

FATHER
12. Name Edward Downing
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma ?
15. Birthplace Virginia

16 (a) Informant Catharine E. Taylor
(b) Address 1922 Penna Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem.
Location md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave

19 SEP 24 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1946, to 9-22-1946, and that I last saw him alive on 9-22 1946.

Immediate cause of death Bronchopneumonia — Duration one day

Due to Bronchitis — unknown

Due to

Other Conditions Myocardial Nephritis and hypertension — unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 9-24-46

VS 150

107

G43989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G43989

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2644 N. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2644 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA VIRGINIA ROMANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Romans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1867

8. AGE: Years	Months	Days	If less than one day
78	9	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Litchfield
13. Birthplace Unknown

MOTHER
14. Maiden Name Ferguson
15. Birthplace

16 (a) Informant Mrs. Edward Hartman
(b) Address 2644 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 24 1946 (Date received by Registrar) Huntington Williams, MD

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1946, at 6:03 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1946 to Sept 22 1946, and that I last saw h[illegible] alive on Sept 22 1946.

Immediate cause of death	Duration
Bronchopneumonia	22
Uraemia coma	42
Due to Chronic Interstitial Nephritis	62
Due to Mitral Regurgitation	64
Other Conditions Coronary Thrombosis	62

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T F O Stevens
Address 2878 Hereford Rd Date signed 9-28-46 M. D.

131a

MARGIN RESERVED FOR BINDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G43990

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 MYRTLE AVE.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 MYRTLE AVE. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR C TRENT.SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Willetta Trent
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 27, 1890
8. AGE: Years 56 Months 1 Days 24 If less than one day hr. min.
9. Birthplace Baltimore, Md.. (Town, county, and state)
10. Usual Occupation Labour
11. Industry or business

FATHER
12. Name Arthur Trent.
13. Birthplace Essex Co. Virginia

MOTHER
14. Maiden Name Mary Crippen.
15. Birthplace Virginia.

16 (a) Informant Vernon Trent.
(b) Address 1027 Myrtle Ave..

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1946. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St

SEP 24 1946 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH SEPTEMBER 20 1946 at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from JANUARY 17.46 SEPT 20, 46. and that I last saw h 1m alive on SEPT 20 1946

Immediate cause of death	Duration
CHRONIC MYOCARDIAL	
Due to DEGENERATION JANY 17.1946	
Due to MITRAL REGURGITATION	1946.
ARTERIOR SCLEROSIS.	1946.

Other Conditions NONE
(Include pregnancy within three months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Chanticr M.D.
Address 3013 ST PAUL ST SEPTEMBER 20 1946 Date signed

643991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 643991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital No 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Ramona Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Chapness Champness

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1877

8. AGE: Years 68 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Ice Cream Maker

11. Industry or business Retired

FATHER 12. Name Joshua Champeness
13. Birthplace Md

MOTHER 14. Maiden Name Ella Simmes
15. Birthplace Md

16 (a) Informant Edw Champeness
(b) Address 3307 Ramona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24/46 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Wilmot Funeral Home
(b) Address 2008 Orleans St.

19 (a) SEP 24 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1946 at 6 45 A.M

21. I certify that I took charge of the remains described above, held an Autopsy - Inq. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Coron. Occulsion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wilmot M.D.
Medical Examiner.
Date signed 9-21-46

VS 151

G43992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G43992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 N. Collington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
4 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Imhoff

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Imhoff
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1892

8. AGE: Years	Months	Days	If less than one day
54	0	16	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Martin Trang
13. Birthplace Germany

MOTHER
14. Maiden Name Catharine Fickenscher
15. Birthplace Germany

16 (a) Informant John Imhoff
(b) Address 1520 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Orleans St

SEP 24 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1946, at 11:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from June – 46 to Sept 22 46 and that I last saw h[illegible] alive on Sept 22 46

Immediate cause of death (Carcinoma, Cervix) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation? Sept 16
Major findings of operation Deep Radium therapy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Hamman M. D.
Address 1 E Chase St Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Komber ✓ 467

G43993 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St
(c) Hospital or institution:
Franklin Square Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~ Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4528 Arabia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Komber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen Komber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-4-1871

8. AGE: Years	Months	Days	If less than one day
75	8	18	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Retired

MOTHER / FATHER
12. Name Herman Komber
13. Birthplace Germany
14. Maiden Name Louisa Fehlen
15. Birthplace Germany

16 (a) Informant Mr John Komber
(b) Address 2013 Brendan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director Jos J Sterrenberg
(b) Address 300 N Kentucky Ave

19 (a) SEP 24 1946 Huntington Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 22 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 22 SEPT 1946.

Immediate cause of death: Carcinoma, rectum — Duration: 1 yr, 4 mos

Due to unknown

Due to

Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation 9/8/46 & 9/19/46

Major findings of operation: Inoperable Carcinoma, rectum

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 1127 N. Paul Date signed 9-23-46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

643994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 643994

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6H
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BESSIE WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/6/1898

8. AGE: Years	Months	Days	If less than one day
48	2	16	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Wilson
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Johnson
15. Birthplace Md.

16 (a) Informant Gladys Wilson
(b) Address 1421 Barnes St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Beverly ave

SEP 24 1946 (Date rec'd by Registrar) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1946, at 3 a. M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/23/46

G13995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G13995

CHK-104592

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28- 6- 8-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 May Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Washington

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14-1918

8. AGE: Years	Months	Days	If less than one day
28	6	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John McKean
13. Birthplace ?

MOTHER
14. Maiden Name Emma Harris
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave.

SEP 24 1946 (c) Signature of Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1946, at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1946, to Sept. 22 1946, and that I last saw h er alive on Sept. 22 1946.

Immediate cause of death Peritonitis, Cause undetermined — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marcy E. McMillan
Address Balto. City Hosp. Date signed 9-24-46

VS 150

G43996 BC# G43996

499586 G54939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2246 Guilford Ave (If no st. give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Genevieve (Rowley Bell) Benden

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-24-46

8. AGE: Years | Months | Days 29. | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name [illegible] (Rowley) (Bell)

13. Birthplace Barnesboro Penna.

MOTHER 14. Maiden Name Amanda Elizabeth Burch

15. Birthplace McKeesport Pa.

16 (a) Informant Records

(b) Address Johns Hopkins

17 (a) Burial [illegible] (Burial, cremation, or removal) (b) Date thereof 9-24-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location City

18 (a) Funeral director Wiedefeld & Son

(b) Address Greenmount Ave & 22nd St

19 (a) SEP 24 1946 (b) [illegible] Washington Boulevard

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 23 1946 at 7.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 24 1946 to Sept 23 1946, and that I last saw him alive on Sept - 23 1946.

Immediate cause of death: Diarrhoea of the Newborn — Duration: 5 days

Due to

Due to

Other Conditions Prematurity — Duration: Life

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H Hardy

Address Johns Hopkins Hosp Date signed 9/23/46

VS 150

G43997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 465

G43997 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Hamilton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan C. Clusman CLUSMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife J. Henry Clusman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23. 1897

8. AGE: Years 59 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Harrisonburg Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Russell
13. Birthplace Harpers Ferry W. Va.

MOTHER 14. Maiden Name Louella Haines
15. Birthplace Harrisonburg Va.

16 (a) Informant J. Henry Clusman
(b) Address 3606 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md.

18 (a) Funeral director D. Howard Storey
(b) 3707 W. North Ave
(c) SEP 24 1946 (Date rec'd by registrar) Ellington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1946, at 4.57 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to Sept 23 1946, and that I last saw h.er alive on Sept 17 1946

Immediate cause of death: Carcinoma of the Colon with regional metastases — Duration 19 months
Due to Un Known
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Aug 2 1946
Major findings of operation: Carcinoma of Colon
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Martin P. Burgunder
Address 1109 St Paul St Date signed 9/26/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G43998

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta F. Sauerwald

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife William H. Sauerwald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1865

8. AGE: Years	Months	Days	If less than one day
80	9 10	21 23	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name August Berndt
13. Birthplace Germany

MOTHER
14. Maiden Name Henretta Pfifer
15. Birthplace Germany

16 (a) Informant Albert Sauerwald
(b) Address 8 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 700 W. Lombard St.

19 Sept 24 1946 Burlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1946, at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7th 1943 to Sept 21st 1946 and that I last saw h[illegible] alive on Sept 9th 1946

Immediate cause of death
Cardio Vascular Disease
Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Jenkins M. D.
Address 10 E. Fulton Ave Date signed 9/23/46

VS 150

1201 POPLAR GROVE
DR ASHMAN
2000 9-10AM-6-9PM

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 643999

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3910 PARK HIGHTS AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 PARK HIGHTS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA. DIETERICH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife GEO G. DIETERICH.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 12 1864

8. AGE: Years	Months	Days	If less than one day old
82	7	10	hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

MOTHER / FATHER
12. Name AUGUST SUCHTING
13. Birthplace GERMANY
14. Maiden Name DOROTHY GROTTING
15. Birthplace GERMANY

16 (a) Informant GEORGE G DIETERICH
(b) Address 3910 PARK HIGHTS AVE

17 (a) BURIAL (b) Date thereof SEPT. 25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST PAULS CEM
Location VIOLETTSVILE MD

18 (a) Funeral director Wm Chas A G Roberts
(b) Address 2327 Edmondson Ave

19 SEP 24 1946 Huntington Williams MD
(Date received) (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 22 1946, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1946, to 9/22 1946, and that I last saw h. alive on 9/22 1946

Immediate cause of death Hypertension C-V-D — Duration ? yrs

Due to Generalized Arteriosclerosis — ? yrs

Due to Senility — ? yrs

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jean Ashman M.D.
Address 1201 Poplar Grove St Date signed 9/23/46

G44000 Wilson 3 W Biddle St Jul 0222 — G44000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1144 CLEVELAND ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 CLEVELAND ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZA RIDGELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 13- 1867

8. AGE: Years	Months	Days	If less than one day
78	11	9	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name FRANK RIDGELL
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY WISE
15. Birthplace MARYLAND

16 (a) Informant MRS ANNA ELLIS
(b) Address 1144 CLEVELAND ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 25 46 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN CEM
Location GLEN BURNIE MD

18 (a) Funeral director Bernard C Hanke
(b) Address 127 E West St

SEP 24 1946 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 22 1946 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1946 to Sept 22 1946, and that I last saw h[illegible] alive on Sept 19 1946

Immediate cause of death Myocardial Insuff — Duration 3 days

Due to Old age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Thos E. Wilson
23. Signature W. Hanke
Address Date signed Sept 23 46

X

G 44000½

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 44000½

Registered No.

CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) [illegible]ore City, Maryland
(b) Usual address 1514 Division St
(c) Hospital or institution: Provident Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 947 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Croxton #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-46

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Croxton
13. Birthplace Virginia

MOTHER
14. Maiden Name Cornelia Sutton
15. Birthplace Virginia

16 (a) Informant (Records at Provident)
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 9/24/46 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1946, at 2 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1946, to Aug 14 1946, and that I last saw him alive on Aug 14 1946.

Immediate cause of death	Duration
Intracranial hemorrhage (newborn)	
Due to Prolonged Labor	
Due to Forceps delivery	
Other Conditions 1st of twins	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pendleton M. D.

Address Provident Hosp. Date signed

X 1-10-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G44001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4214 Belmar Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 Belmar Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustavus B. James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Elizabeth H. James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/1860

8. AGE: Years	Months	Days	If less than one day
85	9	19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Sea Captain
11. Industry or business Retired

FATHER
12. Name Theo. James
13. Birthplace

MOTHER
14. Maiden Name Virginia Jones
15. Birthplace

16 (a) Informant Miss Lillian Jones
(b) Address 4214 Belmar Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 26 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lansburgh Funeral Home
(b) Address 7401 Belair Rd.

19 (a) SEP 24 1946 (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23rd 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946 to Sept 23 1946, and that I last saw h[illegible] alive on 9-23-1946.

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerosis

Due to & Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard Lansburgh

Address 5202 Belair Rd. Date signed 9-24-46.

X

H-44001½

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G-44001½ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 Bridgeview ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore, city
(c) City or town Cherry Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Bridgeview ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Baby Pettiford

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Baby

6 (b) Name of husband or wife Mrs. Benjamin Pettiford
6 (c) If alive, give age 21 + 24 years

7. Birth date of deceased (mo., day, yr.) 6-7-46 at 1 A.M.

8. AGE: Years	Months	Days	If less than one day
—	—	—	0 Hr. 8 min.

9. Birthplace Cherry Hill, Baltimore 25, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Mr. Benjamin Pettiford
13. Birthplace Woodson N. C.

MOTHER
14. Maiden Name Mrs Leola Watson
15. Birthplace Md.

16 (a) Informant Jerry C. Lucky, M.D.
(b) Address 303 Bridgeview ave, Cherry Hill

17 (a) — (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory —
Location —

18 (a) Funeral director —
(b) Address —

19 9/24/46 (Date rec'd by registrar) Huntington Williams, M.D. (signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6 1946, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1946, 1 A.M. to 6-6 1946, 2 A.M. and that I last saw h alive on 6-6 1946.

Immediate cause of death Prematurity

Due to Premature birth-
6 mo fetus

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration
1 hr 8 min

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Jerry C. Lucky M. D.
Address 303 Bridgeview Date signed 6-9-46

VS 150

G44002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓131a

Registered No. G44002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Margaret Ave (If rural give location)
(e) Citizen of foreign country? Essex 21, Md. (Yes or No)
If yes, name country

3 (a) FULL NAME George Friedel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Lisetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1/03

8. AGE: Years	Months	Days	If less than one day
43	5	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Glenn L. Martin

FATHER
12. Name George Friedel
13. Birthplace Md.

MOTHER
14. Maiden Name Magdalene Krause
15. Birthplace Germany

16 (a) Informant Mrs. Lisetta Friedel (wife)
(b) Address 312 Margaret Ave. Essex 21

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Blair Rd

18 (a) Funeral director John D Connelly.
(b) Address 418 Eastern Ave Essex 21

19 (Date rec'd by Registrar) SEP 24 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/46 19 , at 4:32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21/46 to 9/21/46, and that I last saw him alive on 9/20/46

Immediate cause of death	Duration
Uremia due to	
Due to Chr. nephritis	
Due to Hypertensive C.V. disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address St. Josephs Hosp. Date signed 9/21/46

VS 150

X

G44003 AB-104436 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √124a

Registered No. G44003

The spaces provided for information should be carefully supplied. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 745 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ries-or-William Reis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7- 1887

8. AGE: Years	Months	Days	If less than one day
59	7	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Heintman
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgry Rd.

18 (a) Funeral director John D Connelly
(b) Address 418 Eastern Ave.

SEP 24 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19- 1946, 12.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1946, to 9-19 1946, and that I last saw h im alive on 9-19 1946.

Immediate cause of death Uremia — Duration

Due to Hypertension & Arteriosclerotic C-V-R Disease

Due to Nephrosclerosis

Other Conditions Laennec's Cirrhosis Urethral Stricture & Pyonephrosis

(Include pregnancy within 3 months of death)

Date of operation Postponing Cystos

Major findings of operations

of autopsy As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto. City Hosps Date signed 9-19-46

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G44004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto Md.
(c) Hospital or institution: 1137 N. Carrollton Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Samuel Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1872

8. AGE: Years	Months	Days	If less than one day
73 74	9	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Beauty Salons

FATHER
12. Name Levi Fouant
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Ann Nelson
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-25-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Co.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) SEP 24 1946 (Registrar's office) (b) Registrar Wilmington, N.C. (Signature)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1946, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1946 to 9-22 1946 and that I last saw her alive on 6-22-1946.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to	
Due to Cancer Breast,	1 yr. ?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Frame M.D.
Address 2340 Madison Ave Date signed 9-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correspondence is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

G44005

Registered No. G44005

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 EUTAW PLACE. 17
(c) Hospital or institution:
NURSING HOME.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6.MONTH
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND. (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 N. CALVERT STREET.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN DELORES FELDHAUS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm. W. Feldhaus

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Jan 31 1877

8. AGE: Years 49 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Lawrence M. Miller

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Wigler

15. Birthplace Balto Md

16 (a) Informant Mr W W Feldhaus (husband)

(b) Address 2627 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-46 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville - Balto Co

18 (a) Funeral director Stewart Memorial Co.

(b) Address 458 W North Ave

SEP 24 1946

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 23 1946 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 29 1946 to SEPT. 23 1946.
and that I last saw her alive on SEPT 23. 1946

	Duration
Immediate cause of death CHRONIC MYOCARDITIS JULY 29	1946.
Due to MULTIPLE SCLEROSIS.	1935.
Due to ARTERIOR SCLEROSIS.	1936.
Other Conditions NONE.	

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operations: NONE

If autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward F. Beaulieu
Address 5013 SAINT PAUL ST. Date signed SEPTEMBER 23 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G44006 — BALTIMORE CITY HEALTH DEPARTMENT — G44006

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 Roundhill
(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 9
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give location)
(d) Street No. 1534 Roundhill
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Snowden Lore

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Milland F Lore
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 13 1862

8. AGE: Years 84 | Months 0 | Days 10 | If less than one day: hr. min.

9. Birthplace: Calvert Co. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: Richard Dare
13. Birthplace: maryland

MOTHER
14. Maiden Name: Caroline Stinnard
15. Birthplace: maryland

16 (a) Informant: Mrs Edna S. Wallis (wife)
(b) Address: 1537 Roundhill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-46 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn

18 (a) Funeral director: Stewart & Hopper
(b) Address: 108 N Monroe

19 (a) (Date received by Registrar) (b) Registrar: Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 3/46 19 , at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946 to Sept 23 1946 and that I last saw h alive on Sept 23 1946

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to:	
Due to:	
Other Conditions: Pneumonia (left) (2 yrs)	

(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation:
Autopsy: none

If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H Bot Kelly M. D.
Address: 100 N. Linwood Ave Date signed: Sept 24 1946

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

044007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Garrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rockdale (If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Milford Mill Road (If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Edward Steward Aleshire

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hilda B. Aleshire
6 (c) If alive, give age 43 ~~1896~~

7. Birth date of deceased (mo., day, yr.) January 8, ~~1897~~

8. AGE: Years	Months	Days	If less than one day
50 ~~49~~	8	15	hr. min.

9. Birthplace Stanton, Va. (Town, county, and state)
10. Usual Occupation Auto Mechanic
11. Industry or business Garage

FATHER
12. Name Joseph Aleshire
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary E.
15. Birthplace Virginia

16 (a) Informant Mrs. Hilda B. Aleshire
(b) Address 3621 Milford Mill Rd., Rockdale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Reisterstown, Md.

18 (a) Funeral director Hilda L. Amoreau
(b) Address 4510 Liberty Heights Ave.

SEP 24 1946 (Date filed by registrar) (b) _____ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1946, at 10.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Sept 1946 and that I last saw h im alive on Sept 20 1946.

Immediate cause of death — Duration

Coronary Thrombosis

Due to Hypertension

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature C. J. Wolnick M. D.
Address 4710 Liberty Hgts Ave. Date signed 9/23

Huntington Williams, M.D. (acer)

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44008 TN. 103854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44008

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Thames St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 11th 1867

8. AGE: Years 78 | Months Oct | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Bauer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Augusta Ey
15. Birthplace Maryland Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/25/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Schwartz's
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

SEP 25 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 / 1946 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 18/19 46 to Sept 22 19 46 and that I last saw h im alive on Sept 22/19 46

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Arteriosclerotic cardiovascular disease.

Due to

Other Conditions: Benign prostatic hypertrophy (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Tubbs M.D.
Address Balto. City Hosp. Date signed 9/24/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49746

G44009

BALTIMORE CITY HEALTH DEPARTMENT X Registered No. G44009

CERTIFICATE OF DEATH 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick County
(c) City or town Thurmont (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bell - a

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-46

8. AGE: Years	Months	Days	If less than one day
0	0	28	hr. min.

9. Birthplace Gettysburg Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roland Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Kathryn Saylor
15. Birthplace Maryland

16 (a) Informant friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 25-46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Graceland Cem
Location Graceham Md

18 (a) Funeral director M. L. Creager Co
(b) Address Thurmont Md

19 (a) SEP 25 1946 (Date rec'd by Registrar) (Signature for Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1946, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1946, to 9-28 1946, and that I last saw h[illegible] alive on 9-28 1946.

Immediate cause of death: DIARRHOEA OF THE NEWBORN — Duration: 6 days

Due to

Due to

Other Conditions PREMATURITY — LIFE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H Hardy
Address JOHNS HOPKINS HOSP Date signed 9/29/46 (M. D.)

VS 150

G44010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G44010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 - N. Carrollton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 - N. Carrollton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary M. Stone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Chas. C. Stone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1870

8. AGE: Years	Months	Days	If less than one day
76	1	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name George Gossage
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Albany N. Y.

16 (a) Informant Francis H. Riley
(b) Address 23 N. Carrollton Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/26/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 647 St. Paul St.

19 (a) SEP 25 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1946, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an ~~inquest~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/24/46

G44011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G44011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution: Aged Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY GOLDSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Joseph

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Israel
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Ruben Goldstein
(b) Address 24 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-46 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle
Location Mt Carmel

18 (a) Funeral director Jack Levin Jew
(b) Address 1439 E. Baltimore

19 SEP 25 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1946, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1946 to 9-24 1946, and that I last saw h[illegible] alive on 9-24 1946.

Immediate cause of death Cerebral Arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin, M.D.
Address Lewindale Date signed 9/25/46

VS 150

G44012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946a

Registered No. G44012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Jonquil Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Jonquil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS LEVINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife EMMA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JACOB LEVINSON
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant HENRY LEVINSON - SON
(b) Address 3827 MENLO DRIVE

17 (a) BURIAL (b) Date thereof 9-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MOSES MONTIFORE
Location WASH RD.

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO ST

19 SEP 25 1946 Huntington Williams MD
(Date received by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 1946 at 7 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1946 to 9/24 1946 and that I last saw him alive on 9/24 1946

Immediate cause of death Coronary Thrombosis — Duration 1 hr.

Due to Coronary Arteriosclerosis — ?

Due to

Other Conditions Previous attack about 6 weeks ago
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sharfstz, M. D.
Address 516 Park Heights Ave Date signed 9/24/46

VS 150

544013 HEALTH DEPARTMENT—CITY OF BALTIMORE 544013

CERTIFICATE OF DEATH ✓ 131a

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 340 Bloom 4th St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Laura Virginia Washington

If U. S. Veteran specify WAR

(a) Residence: No. 340 Bloom St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	Col	widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Washington

6. DATE OF BIRTH (month, day, year) Sept 1st 1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	-	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Howard Co., Maryland

FATHER

13. NAME Alfred Gr. Valentine

14. BIRTHPLACE (city or town) (State or country) Howard Co., Maryland

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Howard Co., Maryland

17. INFORMANT Mrs Grace Welsh

(Address) 340 Bloom St Baltimore Md

18. BURIAL, CREMATION, OR REMOVAL

Place Lutherus Memorial Date 9-26 19 46

19. UNDERTAKER Archibald R. Gaddis

(Address) 2101 McCulloh St

20. SEP 25 1946 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) September 23rd 1946

22. I HEREBY CERTIFY, That I attended deceased from June 2nd 1946 to September 23rd 1946

I last saw h[illegible] alive on September 22nd 1946 Death is said to have occurred on the date stated above, at 5:30 P.

The principal cause of death and related causes of importance were as follows:

Chronic parenchymatous nephritis

Date of onset

Other contributory causes of importance:

Arteria-Sclerosis

Was an operation performed? no Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? None Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, when?

(Signed) C. H. Thomas M. D.

(Address) 107 N. Main St. Bel Air Md.

X

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G44014 Over BALTIMORE CITY HEALTH DEPARTMENT G44014

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 E. Baltimore st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 E. Balto st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hebbert

3 (b) If vetetan, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1946

8. AGE: Years | Months | Days | If less than one day: 1 hr. 25 min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Geo. J. Hebbert
13. Birthplace Balto

MOTHER 14. Maiden Name Maufee Law
15. Birthplace Balto

16 (a) Informant Geo. J. Hebbert
(b) Address 2013 E Balto st

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-28-46 (month) (day) (year)

(c) Cemetery or crematory Mt Pleasant
Location Balto Md

18 (a) Funeral director Frank Burnthorn
(b) Address 800 N. Eberlin st

SEP 25 1946 (Date rec'd by registrar) (b) Interring for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1946 and that I last saw h alive on Sept 24 1946

Immediate cause of death — Duration

(a) Prem Fetus — Birth

Due to Premature

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 802 N Williams Date signed 9-29-46

G44015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 122a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Worcester Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Mc Cleary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Elizabeth G. McCleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1872

8. AGE: Years	Months	Days	If less than one day
73	10	23	hr. min.

9. Birthplace Chestnut Ridge, Balto.Co., Md.
(Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business

FATHER
12. Name Nelson McCleary
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Martha Gill
15. Birthplace Baltimore County, Md.

16 (a) Informant Charles E. McCleary, Jr.
(b) Address 610 Worcester Rd., Towson, Md.

17 (a) Burial (b) Date thereof 9/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carroll's Chapel
Location Chestnut Ridge, Md.

18 (a) Funeral director John O. Mitchell & Sons Co.
(b) Address 1900 Eutaw Place

1946 SEP 25 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1946, at 3 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1946, to 9/23 1946, and that I last saw him alive on 9/23 1946.

Immediate cause of death	Duration
Bronchopneumonia - Bilateral	
Due to General Debility	
Due to Operation and Repair of Hernias	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/12/46
Major findings of operation: Hernias - Epigastric, umbilical, left inguinal
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph F. Adams M.D.
M. D.
Address 10 E. Lexington St. Date signed 9/25/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44016

CWK-10A496

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G44016 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Dorsey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife William Dorsey (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2-1866

8. AGE: Years	Months	Days	If less than one day
80	1	21	hr. min.

9. Birthplace Washington-D.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Cox
13. Birthplace District of Columbia

MOTHER
14. Maiden Name Julia Porter
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Sept 26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 463 N. Carey St
18 (c) (Date received by local registrar) Huntington Williams, M.D.
SEP 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1946 at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1946 to Sept. 23 1946, and that I last saw her alive on Sept. 23 1946.

Duration

Immediate cause of death Respiratory Failure
Due to Cerebral Hemorrhage
Due to
Other Conditions Hypertensive Cardiovascular Renal Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: and as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Balto. City Hosp. Date signed 9-24-46
M.D.

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

644017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

Registered No. 644017

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5203 Maple Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Maple Avenue
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth May Neet (Knapp)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Neet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1883

8. AGE: Years 63 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Charles L. Sheets
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura O. White
15. Birthplace Baltimore

16 (a) Informant John Neet
(b) Address 5203 Maple Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Taylor Ave Baltimore

18 (a) Funeral director Lowry Byers
(b) Address 5005 Park Heights Ave.

19 SEP 25 1946 Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1946, at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 9-24-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G44018

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 574 W. Conway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 574 W. Conway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Hull

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Roberta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1898

8. AGE: Years 48 | Months 4 | Days 14 | If less than one day: hr. min.

9. Birthplace Plymouth, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Oil Co.

FATHER
12. Name Edward
13. Birthplace N. C.

MOTHER
14. Maiden Name Ella Mayo
15. Birthplace N. C.

16 (a) Informant Roberta Hull
(b) Address 574 W. Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James Addison
(b) Address 1472 Westfield St

19 (a) SEP 25 1946 Huntington Williams, M.D. Address 1522 Harlem Ave. Date signed 9/25/46

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1946, at 7.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23/46 to 9/24/46 and that I last saw him alive on 9/24 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 2 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Leyton

VS 150

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

644019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83 B

644019 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument Street
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Lamont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Lowery Anna Loretta M. Lowrey

3 (b) If veteran, name war: None

6 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William T. Lowrey
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1876

8. AGE: Years: 70 | Months: 1 | Days: 11 | If less than one day: XXXX hr. XXXX min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: George W. Hoffman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Margaret Mc Gee
15. Birthplace: Baltimore, Md.

16 (a) Informant: William T. Lowery
(b) Address: 1702 Lamont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)
(c) Cemetery or crematory: Medowridge Memorial
Location: Annapolis Blvd

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) SEP 25 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1946 at 4 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1946 to Sept 24 1946, and that I last saw her alive on Sept 24 1946

Immediate cause of death: Cerebral Embolism — Duration: 3 days

Due to:

Due to:

Other Conditions: Femoral Artery (left) occlusion
(Include pregnancy within 3 months of death)

Date of operation: Sept 23, 1946

Major findings of operation: Thrombus in left femoral artery

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Perelman, M. D.
Address Sinai Hospital Date signed Sept 24, 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G44020

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1555 Carswell Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1555 Carswell St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara A.C.Getner

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Jacob H.Getner
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb. 9th., 1869

8. AGE: Years	Months	Days	If less than one day
77	7	14	##### min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name ? Manthey
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Violet C. Sawyer (Daughter)
(b) Address 1555 Carswell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell Street

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (b) Huntington Williams, M.D.
(Signature and title)

SEP 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1946, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 15 Sept 1946 to 23 Sept 1946 and that I last saw h[illegible] alive on 23 Sept 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 6 days
Due to Acute Circulatory Failure.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature James E White M. D.
Address 5214 Harford Date signed 9-28-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C44021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. C44021

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CATON & HILLEN AVES
(c) Hospital or institution: ST. AGNES HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4216 VERMONT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA L. NUSBAUM (ANNA L. NUSBAUM)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Levi Nusbaum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10-1849

8. AGE: Years 97 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Wm GRUMBINE

13. Birthplace Md

MOTHER 14. Maiden Name Margaret Mitchel

15. Birthplace Md

16 (a) Informant Carroll L. Tucker

(b) Address 4216 Vermont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27-46 (month, day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Ralph C. B. M. Walter

(b) Address Walter Funeral Home

19 SEP 25 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1946, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1946 to 9-24 1946, and that I last saw her alive on 9-24 1946

Immediate cause of death respiratory failure — Duration

Due to Fx skull fracture

Due to shock

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/4

(a) Accident, suicide, or homicide

(b) Date of occurrence Sept. 24 1946 at 2:30 A.M

(c) Where did injury occur? Baltimore (City or town) Md (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work?

(e) Means of injury fell down 23 steps

23. Signature H. J. Yankopolus M. D.

Address St Agnes Hosp Date signed

Howard J. Mullis, M.D.

G44022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170C

Registered No. G44022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Havenwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lee Hines

3 (b) If veteran, name war: World War #1 & #11
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Grace Englar Hines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1900

8. AGE: Years 46 | Months 7 | Days 10 | If less than one day: hr. min.

9. Birthplace Uniontown, Md.
(Town, county, and state)

10. Usual Occupation Ass't. Branch Mgr.
11. Industry or business Lee Coca Cola Co.

FATHER
12. Name Emanuel M. Hines
13. Birthplace Hampstead, Md.

MOTHER
14. Maiden Name Mollie L. Spielman
15. Birthplace Linwood, Md.

16 (a) Informant Mrs. Grace E. Hines
(b) Address 1205 Havenwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)
(c) Cemetery or crematory Winters Cem.
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1946, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured heart
Bilateral hemothorax
Fractured ribs
Fractured leg bones
Fractured ulna, forearm, & wrist bones
Other Conditions Lacerations, Bruised kidneys, and bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24-46 at 9/2 7:00 A. M.
(b) Where did injury occur? Loch Raven Blvd & Alameda
(c) Did injury occur at home, on farm, industrial place, in public place? private While at work? no
(d) Means of injury Auto & Auto Collision

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-24-46

G44023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1222

G44023

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ark. (b) County Pulaski
(c) City or town Little Rock
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 S. Tyler St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY LEE BOND

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mabel Elizabeth Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1889

8. AGE: Years	Months	Days	If less than one day
56	11	1	hr. min.

9. Birthplace Sullivan, Ill. (Town, county, and state)
10. Usual Occupation Sales Truck Mgr.
11. Industry or business Dodge Motor Co.

FATHER
12. Name Theodore L. Bond
13. Birthplace Coles Co., Ill.

MOTHER
14. Maiden Name Dora Linder
15. Birthplace Coles Co., Ill.

16 (a) Informant Mrs. Mabel Elizabeth Bond
(b) Address 1602 S. Tyler St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/25/46 (month) (day) (year)
(c) Cemetery or crematory Pine Crest Mem. Park
Location Little Rock, Ark.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Sept 1946 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Sept 1946 to 24 Sept 1946 and that I last saw h. alive on 24 Sept 1946

Immediate cause of death Heart failure — Duration

Due to Bowel obstruction

Due to

Other Conditions Toxemia

(Include pregnancy within 3 months of death)

Date of operation 12 Sept 46

Major findings of operations Bowel obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard A. Pratt M.D.
Address Sinai Hosp. of Baltimore Date signed 24 Sept 46

VS 150

G44024

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH V161c

Registered No. G44024

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Middle River
(c) City or town 10 S. Bolling Road.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md.
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME John Rogers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife — 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 19 1946

8. AGE: Years	Months	Days	If less than one day
		6	hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Rodgers
13. Birthplace New Jersey

MOTHER 14. Maiden Name Mary Wood
15. Birthplace New Jersey

16 (a) Informant Joseph Rodgers
(b) Address 1105 Bolling Rd

17 (a) Burial (b) Date thereof 9/26/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location Glenn Dale Md

18 (a) Funeral director Lilly & Zeiler
(b) Address 1183 N Pitcher St

19 SEP 25 1946 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24th 1946, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1946 to Sept 24 1946 and that I last saw him alive on Sept 24th 1946.

Immediate cause of death	Duration
Cardio-Respiratory failure.	
Due to Pulmonary edema	
Due to Portal Congestion due to Hemolytic anemia due to	
Other Conditions Erythroblastosis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hemorrhagic Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature John B. Wells
Address 310 Jos Hop Date signed 9-24-46

111c

644025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 644025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 E Fairmount Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha A. Sapp

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William O
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	5	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Mathias Dorsch
13. Birthplace Germany

MOTHER
14. Maiden Name Louise
15. Birthplace Germany

16 (a) Informant Dorothy Sapp
(b) Address 2035 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dysel's Sons
(b) Address Lombard & Ann Sts.

SEP 25 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1946 at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1946 to Sept 24 1946, and that I last saw h[illegible] alive on Sept 24 1946.

Immediate cause of death Cerrebral Hemorrhage — Duration 11 days
Due to Pulmonary Edema — 1 day
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jos. L. Valentine, M.D.
Address 1752 N. Broadway Date signed 9/25/46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1222a

Registered No. 44026

FG 44026 B-104553

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Macon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Wolfer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5- 187?

8. AGE: Years	Months	Days	If less than one day
69	3	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name August Wolfer
13. Birthplace Germany

MOTHER
14. Maiden Name Mollie T.
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) (b) Huntington Williams, M.D.

SEP 25 1946

VS-150

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH September 20- 1946, at 5.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1946, to 9-20 1946, and that I last saw h. in alive on 9-20-46 19 .

Immediate cause of death	Duration
Respiratory failure	
Due to Emphysema	
Early Hypostatic Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Emphysema, Early Hypostatic Pneumonia
of autopsy: Diaphragmatic Hernia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Walker M. D.
Address B. C. H. Date signed 9/22/46

G44027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44027 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Marley Neck
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Dixon

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: C
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 10-22-1886
8. AGE: Years 59 | Months 11 | Days 1 | If less than one day: hr. min.
9. Birthplace: Marley Neck Anne Co., Md. (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business:
12. FATHER Name: James Body
13. FATHER Birthplace: Marley Neck, Anne Co, Md
14. MOTHER Maiden Name: Lottie Henson
15. MOTHER Birthplace: Marley Neck, Anne Co. Md.
16 (a) Informant: Sadie Gaither
(b) Address: 1505 E. Fayette St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory: John Wesley
Location: Marley Neck, Anne Co. Md.
18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Belmont Lane
19 (a) Date received by registrar: SEP 25 1946 (b) Registrar: Washington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Sept 1946 at 6:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: William T. Shepherd M.D. Medical Examiner.
Date signed: 24 Sept 46

G44028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G44028 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 W. Lanvale st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 800 W. Lanvale st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Harmon.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Melton
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-10-1904

8. AGE: Years	Months	Days	If less than one day
41	10	13	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Va

MOTHER
14. Maiden Name Katie Watts
15. Birthplace Va

16 (a) Informant Charles Smith
(b) Address 320 Hanover st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 26 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location B. C. County Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

SEP 25 1944 Huntington Williams Mgr (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1944, at 8 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1944 to 9/23 1944, and that I last saw h[illegible] alive on 9/10 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] 9/24 M. D.

VS 150

G.A. Merrill MD x medical examiner

G44029 G44029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1830 E Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 14
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 E Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Abalum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	25	hr. min.

9. Birthplace Halifax County Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert Hart
13. Birthplace Va.

MOTHER
14. Maiden Name Hannie Easley
15. Birthplace Va.

16 (a) Informant Florence Hicks
(b) Address 1437 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26 '46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location G.G. County Md

18 (a) Funeral director Mrs. Ella V. Elliott Dy.
(b) Address 1129 N Carlton St

19 (a) Transit Clinton Williams, Registrar (Date received by registrar) SEP 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21st 1946 at 10.58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/1946 to 9/21/1946 and that I last saw her alive on 9/21/1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: Hypertension

Due to: Hypocardia

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elbert A. Reford

Address 822 N. Bond St Date signed 9/24/46 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44030 Dupes

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G44030

CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 12 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Middle Riv (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Bethesda Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Groves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 46

8. AGE: Years	Months	Days	If less than one day
			1 hr. 12 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert G Groves
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Joyce Lewis
15. Birthplace Wash D C

16 (a) Informant ROBERT GROVES JR.
(b) Address 6404 DOGWOOD ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN, MD.

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST.

19 (a) Date received SEP 25 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1946, at 2:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1946 to 9-24 1946, and that I last saw h[illegible] alive on 9-24 19

Immediate cause of death Cardio Respiratory Failure.

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hamilton Smith M.D.
Address St Agnes Hosp. Date signed 9-25-46

Registrar

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

589

G44031 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 Howard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula Mae TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace Scranton, Penna. (Town, county, and state)

10. Usual Occupation Bar. maid

11. Industry or business

FATHER
12. Name John B. Newmyus.
13. Birthplace Scranton, Penna.

MOTHER
14. Maiden Name Lula Stevenson
15. Birthplace Carlisle Penna.

16 (a) Informant Albert Neivmeius.
(b) Address 122 W. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) SEP 25 1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22- 1946, at 11 A.M.

21. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Alcoholism
Rheumatic heart disease, with rheumatic mitral valvulitis, and acute congestive heart failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/23/46

VS 191

8

X

G44032 ✓ G44032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: St Josephs Hosp.
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5418 Remell Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME OBERENDER, Miss Rena E

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/4/1900

8. AGE: Years 46 Months 8 Days 21 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Typist

11. Industry or business

FATHER 12. Name Henry V. OBERENDER

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Elizabeth SCHARON

15. Birthplace Balto Md.

16 (a) Informant Lulu R. Oberender

(b) Address 5418 Remmell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/46 (month) (day) (year)

(c) Cemetery or crematory Park Wood Cem.

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd.

19 (a) (b) (Date received by registrar) Lexington Williams, M.D. Registrar

25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1946 at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1946 to Sept 25 1946 and that I last saw her alive on Sept 25 1946.

Immediate cause of death: Papillary Adeno-Carcinoma of Ovary

Due to With Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard A. Young M.D.

Address St. Joseph Hosp. Date signed 9/25/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Aves.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 German Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA M. LUNDQUIST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife O. Wm. Lundquist
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1892.

8. AGE: Years	Months	Days	If less than one day
54	6	4	hr. min.

9. Birthplace Mass. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Wm. Hamilten
13. Birthplace Unknown

MOTHER
14. Maiden Name Theresa
15. Birthplace Unknown

16 (a) Informant Mr. O. William Lundquist.
(b) Address 43 German Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27/46. (month) (day) (year)
(c) Cemetery or crematory Leuden Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry W. Leitze.
(b) Address 4101 Edmondson Ave.

19 Sept 25 1946 Huntington Methodist, MD
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1946 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1946, to Sept. 25 1946 and that I last saw h[illegible] alive on Sept. 25 1946

Immediate cause of death	Duration
Hyperthermia	1 day
Due to Cerebral Hemorrhage	1 Day
Due to Cerebral arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard E. Blumenthal M. D.
Address W B G H Date signed 9/25/46

VS 150

G44034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G44034 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution St. Joseph's Hospital
(d) Length of stay in hospital or other institution (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Gillenwater Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Sapanero (In Country 30 Yrs.)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: W F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Husband | If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1/5/92

8. AGE: Years 54 | Months 8 | Days 20 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Vito Griece

13. Birthplace Italy

14. Maiden Name Mafolino

15. Birthplace Italy

16 (a) Informant Mr. Felix Sapanero (Son)
(b) Address 100 S. Kossuth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28/46 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Harry A. Wiehe
(b) Address 4101 Edmondson Ave.

19. (a) (b) (Filled by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1946 to 9/25 1946 and that I last saw h alive on 9/25 1946.

Immediate cause of death: Carcinoma of Splenic flexure of colon — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/23/46

Major findings of operation: Inoperable Ca of Splenic flexure of colon

Autopsy?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. S. Stevens X

Address St. Joseph's Hosp Date signed 9/25/46

Huntington Hillcrest

G44035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G44035 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Lyndhurst St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph G. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Helen G. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1898

8. AGE: Years	Months	Days	If less than one day
48	7	16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Police Man
11. Industry or business S. W. District

FATHER
12. Name George Wilson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. North
15. Birthplace Baltimore

16 (a) Informant Mrs. Helen G. Wilson
(b) Address 900 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Henry F. Miller
(b) Address 4101 Edmondson Ave.

19 (a) 1946 (b) Registered by Christine Williams M.R. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1946, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1946, to Sept. 23 1946 and that I last saw him alive on Sept. 23 1946.

Immediate cause of death	Duration
Cardiac - Resp. Failure	
Due to Acute Congestive Heart Failure	
Due to Coronary Thrombosis & Senility Shock	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. T. Connor M. D.
Address Mercy Hosp. Date signed 9-24-46

VS 150

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G44036 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~3206 Harwell Ave~~
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3206 Harwell Ave (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mrs. Mary Ann Harvey

3 (b) **If veteran, name war** —

3 (c) **Social Security Account No.** —

4. **Sex** F.

5. **Color or race** White

6 (a) **Single, married, widowed, or divorced** Married.

6 (b) **Name of husband or wife** George A. Harvey

6 (c) **If alive, give age** years

7. **Birth date of deceased (mo., day, yr.)** 9/29/14

8. **AGE:** Years 31 | Months 11 | Days 24 | If less than one day hr. min.

9. **Birthplace** Maryland. (Town, county, and state)

10. **Usual Occupation** House wife.

11. **Industry or business** — at home

FATHER
12. **Name** Richard C. Brockmeyer
13. **Birthplace** Maryland.

MOTHER
14. **Maiden Name** Barbara Ulrich
15. **Birthplace** Md.

16 (a) **Informant** Union Memorial Hospital
(b) **Address** Records Dept.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/46 (month) (day) (year)
(c) **Cemetery or crematory** Parkwood
Location Balto. Co.

18 (a) **Funeral director** E. J. Flannery & Son
(b) **Address** 1938 E. Lafayette Ave.

19 (a) 9-26-1946 (Date received by registrar) (b) Registrar

Thursday for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Sept 23 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1946, to Sept 23 1946, and that I last saw h[illegible] alive on Sept 23 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Hypernephroma	
Due to Metastesis to spinal cord, liver and adrenals.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Spinal Tumor

of autopsy: Hypernephroma.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** Edwin O. Hendrickson M.D.
Address Union Memorial Hosp. Date signed 9/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-106648 G44037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G44037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: David Bearden Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-25- 1906

8. AGE: Years	Months	Days	If less than one day
40	0	0	hr. min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Bethlehem Steel Co

FATHER
12. Name Jesse Bearden (D
13. Birthplace Ky.

MOTHER
14. Maiden Name Bessie McKenny
15. Birthplace Ky.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/26/46 (month) (day) (year)
(c) Cemetery or crematory Steubensville
Location Ohio

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b)

SEP 26 1946 Huntington, Williamson, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25- 1946, at 3.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20- 1946 to 9-25- 1946, and that I last saw him alive on 9-25- 1946.

Immediate cause of death	Duration
Uraemia	1 week
Due to Hypertensive C.V. Dis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Russell Hoffman M. D.
Address Baltimore City Hospitals Date signed 9-26-46

X

G44038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B V

G44038 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 553 Robert St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 553 Robert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otho Young

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	M

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/30/1884

8. AGE: Years	Months	Days	If less than one day
61	8	24	hr. min.

9. Birthplace Balto Md (town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Emory Young
13. Birthplace Md

MOTHER
14. Maiden Name Mary Tobb
15. Birthplace Md

16 (a) Informant Elizabeth Young
(b) Address 553 Robert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)

(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Pressman St

18 (c) Registered by Huntington Williams, M.D.

SEP 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1946, at 6 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1946, to Sept 23 1946, and that I last saw him alive on 9-23 1946

Immediate cause of death	Duration
Mitral Insufficiency	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Fisher
1612 Division St M. D.
Date signed 9/27/46

G44039

501088.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 125a

G44039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: John Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 Spring Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Boone.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-38

8. AGE: Years	Months	Days	If less than one day
8	3	6	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Natale Boone
13. Birthplace Pa.

MOTHER 14. Maiden Name Catherine Ojello
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Septe. 27 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 26 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1946, at 6.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1946 to Sept. 24 1946, and that I last saw h[illegible] alive on Sept. 24 1946

Immediate cause of death	Duration
Acute liver atrophy	
Due to ? Virus Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Hardy

Address JOHNS HOPKINS HOSP Date signed M. 9 D. 24/46

X

G44040 BC# 953498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G44040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 CAROLINE ST
(c) Hospital or institution: ST JOS. HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTO. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 CLIFTMONT. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE A. DUKES.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6(a) Single, married, widowed, or divorced S.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/5/46
8. AGE: Years | Months 1 | Days 19 | If less than one day hr. min.
9. Birthplace BALTO, MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Wadelson Dukes
13. Birthplace Balt Md
MOTHER 14. Maiden Name Kathryn Kirby
15. Birthplace Wilkes Co. Ga

16 (a) Informant Mrs. Dukes
(b) Address 3305 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Dundalk

18 (a) Funeral director Joseph Lasemakis Jr
(b) Address 602 Washington Blvd

19 (a) [illegible] Washington Hillsboro, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1946 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on 9-24 1946

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE.	
Due to PULMONARY EDEMA	
Due to INTESTINAL OBSTRUCTION	
Other Conditions INCARCERATED HERNIA	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations GANGRENOUS BOWEL
Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John B Wells M.D.
Address St Jos Hosp Date signed 9-25 1946

VS 150

G44041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G44041 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3825 Penhurst Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 → 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3825 Penhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE P. SMITH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George W. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1870

8. AGE: Years 75 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Ruse
13. Birthplace France

MOTHER
14. Maiden Name Laura Arnold
15. Birthplace Md.

16 (a) Informant Mrs. Jeannette Kinsey
(b) Address 3825 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 26 1946 Huntington Williamsville, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1946 at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1946 to Sept 23 1946 and that I last saw h alive on Sept 22 1946.

Immediate cause of death: Myocardial Insufficiency — Duration: 2 mos 13 da
Due to Arterial Sclerosis — 8 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G W Bellenger M. D.
Address 2224 N. North Ave. Date signed Sept 27/46

X

G44042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G44042

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hallie Leola Vaughan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1946

8. AGE: Years | Months: 4 | Days: 12 | If less than one day: hr. min.

9. Birthplace Deer Park Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name not married.
13. Birthplace

MOTHER — 14. Maiden Name Alvia Loala Vaughn.
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 29, '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Deer Park
Location Reisterstown, Md.

18 (a) Funeral director Hugo B Spreyman & Son
(b) Address Reisterstown, Md.

19 (a) (Date received by Registrar) (b) Registrar

SEP 26 1946

Huntington Williams, Md.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1946 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1946, to 19, and that I last saw h alive on Sept 25 1946.

Immediate cause of death Cardiac failure — Duration

Due to Bronchopneumonia, bilateral

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Dorsett M.D.
Address Johns Hopkins Hospital Date signed Sept 27 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G44043

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Shakespeare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1871

8. AGE: Years	Months	Days	If less than one day
74	9	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Jonathan Shakespeare

13. Birthplace Md

14. Maiden Name Amanda Keouch

15. Birthplace Md

16 (a) Informant Mrs Grace Gunn

(b) Address 2220 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave

18 (a) Funeral director John F Denny Inc

(b) Address 715 Light St. Station Williams, Md

19 (a) SEP 26 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1946, at 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 19__ to Sept 22 1946 and that I last saw h[im] alive on Sept 22 1946.

Immediate cause of death: Cardiac Decompensation — Duration: 2 days

Due to: Arteriosclerosis — 6 years

Due to:

Other Conditions: Obstructive jaundice Duke, Ascites, Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Biliary obstruction choque

of autopsy: adhesions + Gall stones

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Southwick, M.D.

Address Franklin Sq Hosp Date signed 9/27/46

95c

G44044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176B

G44044 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Beach (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Welton Strickland

3 (b) If veteran, name war

3 (c) Social Security Account No. 253-07-0863

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucille L. Robinson

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1910

8. AGE: Years 36 | Months 6 | Days 27 | If less than one day: hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Sam Strickland
13. Birthplace Georgia

MOTHER
14. Maiden Name Eula Dammons
15. Birthplace Georgia

16 (a) Informant Mrs Lucille Strickland
(b) Address Chelsea Rd, Riviera Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/46 (month) (day) (year)
(c) Cemetery or crematory Loring Ton Cem
Location Loring Ton Geo.

18 (a) Funeral director John F Henny Inc
(b) Address 715 Light St.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1946 at 2:05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured diaphragm
Hemothorax

Due to

Other Conditions: Fractured ribs, multiple fractures, lacerations, bruised lung and kidney (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-23-46 at 7P M.
(b) Where did injury occur? Randall & Light Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. Struck by streetcar

23. Signature Howard A Mackeis M.D.
Medical Examiner.
Date signed 9-25-46

VS 181

G44045
501261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G44045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Oregon (b) County
(c) City or town Portland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 440 N.E. Morris St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Neil Munsden Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-2-38

8. AGE: Years	Months	Days	If less than one day
8	6	23	hr. min.

9. Birthplace Montana
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Neil Munsden
13. Birthplace Monta

MOTHER
14. Maiden Name Florence Hughes
15. Birthplace Monta

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept 24/46 (month) (day) (year)

(c) Cemetery or crematory
Location Portland Oregon

18 (a) Funeral director John C. Mitchell Son.
(b) Address 1900 Eastern Place.

19 (a) (Signature of registrar) Registrar

SEP 26 1946

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 25 1946 at 7.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1946 to Sept. 25 1946 and that I last saw h. alive on Sept. 25 1946.

Immediate cause of death: Pulmonary edema — Duration 1 d.

Due to: Operation for

Due to: Pulmonary Stenosis — Duration Life

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-24-46

Major findings of operation: Pulmonary Stenosis.

of autopsy: Pulmonary edema.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. S. Morrow M. D.
Address J.H.H. Date signed 9-25-46

G44046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G44046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 W. Boyd St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Cline, Molly W.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Samuel T. Cline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19th 1883

8. AGE: Years	Months	Days	If less than one day
63	8	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at Home

MOTHER / FATHER
12. Name (Unknown) Schmidt
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Anna Cline
(b) Address 1160 Cleveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar
SEP 26 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1946 at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1946 to Sept 24 1946, and that I last saw h[illegible] alive on Sept. 24 1946

Immediate cause of death	Duration
circulatory collapse	
General Arteriosclerosis	
Due to Senile Gangrene of both legs	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert Harris
Address Franklin Sq Hosp Date signed 9/24/46 M.D.
Howard S. Liebman, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G44047 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 154 N. East Ave.
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 154 N. East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Kahler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph J. Kahler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16/83

8. AGE: Years	Months	Days	If less than one day
62	9	9	hr. min.

9. Birthplace Balto. Co. Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Edw. J. Herrmann
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Emma Naimaster
15. Birthplace Balto. Co. Md.

16 (a) Informant Joseph J. Kahler
(b) Address 154 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 28 46 (month) (day) (year)
(c) Cemetery or crematory Zion Luth. Cem.
Location Balto. Co. Md.

18 (a) Funeral director Rosedale Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS SEP 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25-26 - 1946 at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1-45 to Sept 25-46 and that I last saw her alive on Sept 23 1946

Immediate cause of death Carcinoma R Lung — Duration 3 mos

Due to Carcinoma R Breast — 8 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 45

Major findings of operation: Carcinoma R Breast

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Herrmann M.D.

Address 1710 E 33rd St Date signed 9/26/46

Huntington Hospital

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G44048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 139a

G44048

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, giving town)
(d) Street No. 413 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** LOUISE KENNEDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1900

8. AGE: Years 46 | Months 2 | Days 20 | If less than one day: hr. min.

9. Birthplace S. C (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Durant
13. Birthplace S. C

MOTHER
14. Maiden Name Olivia Laws
15. Birthplace S. C.

16 (a) Informant Edith Holley
(b) Address 443 Pittman Place

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-27-46 (month) (day) (year)
(c) Cemetery or crematory Florence
Location South Carolina

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (c) Date received SEP 26 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25- 1946, at 12:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Peritonitis, due to
ruptured tuboovarian abscess
~~Due to~~ on right.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/25/46

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

244049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. 244049

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1505 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Wm C. Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/4/1925

8. AGE: Years	Months	Days	If less than one day
21	7	20	hr. min.

9. Birthplace Anne Arundel County (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Shedrach Davis
13. Birthplace Anne Arundel Co. Md

MOTHER
14. Maiden Name Ella Kess
15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Shedrach Davis
(b) Address A. A. Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/46 (month) (day) (year)
(c) Cemetery or crematory Marley Neck Ct
Location A. A. Co. Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) 9-26-1946 (Date filed by Registrar) (b) Lexington Millionaire M

S.D. 2

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1946, at 9.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Intracranial hemorrhage
Rupture of spleen
Intra-abdominal hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 19 2

(a) Date of injury 9-24-46 at 8.10 a. M.
(b) Where did injury occur? Calhoun & Lexington Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pass. auto & auto collision

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 9-24-46

X

644050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 644050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 S. East Aye.
(c) Hospital or institution:

26-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. East Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH BERGUNT

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	none	female	white	Widowed

6 (b) Name of husband or wife August Bergunt
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) June 2,1835

8. AGE: Years	Months	Days	If less than one day
81	3	21	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wanger
13. Birthplace Germany

MOTHER
14. Maiden Name ? Martin
15. Birthplace Germany

16 (a) Informant Mrs.Lillian Shane
(b) Address 117 S.East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.27.46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS.INC.
(b) Address BALTIMORE MD.

19 (a) (Date rec'd by registrar) (b) Williams, Registrar

SEP 26 1946 Huntington 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.23.1946 at 11.50P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1946 to Sept 23 1946 and that I last saw him alive on 19

Immediate cause of death
Cerebral Hemorrhage
Due to Senility
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature
Address 1125 St Paul St Date signed 9/26/46

X

G44051 Lobe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G44051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rochester Court Apts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Rochester Court Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) (If yes, name country)

3 (a) FULL NAME Ferdinand P. Lobe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maude H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md (City or county, and State)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Philip
13. Birthplace Germany

MOTHER
14. Maiden Name Mary
15. Birthplace Newark N J

16 (a) Informant Maude H. Lobe
(b) Address Rochester Court Apts

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-27-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1407 E Baltimore St

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

VS SEP 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25- 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1937 to Sept. 1946 and that I last saw h Him alive on 25 Sept. 1946

Immediate cause of death	Duration
Myocardial infarction	2 hours
Due to Coronary thrombosis Coronary Sclerosis	
Due to Myocardial infarction and coronary thrombosis	3½ years

Other Conditions None (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None.

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. C. Thompson Jr.

Address 1227 Eutaw Place Date signed 9-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44052 BC# G52820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190a

Registered No. G44052

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18
(c) Hospital or institution: BON SECOURS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Mc ALEAR CT. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERRY LEE GRAMMER ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG 2-1946

8. AGE: Years	Months	Days	If less than one day
	1	23	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name MICHAUS GRAMMER
13. Birthplace VA.

MOTHER
14. Maiden Name VIOLA CANTORE
15. Birthplace BALTO MD

16 (a) Informant MR MICHAUS GRAMMER
(b) Address 1129 McALEAR CT.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 8/31/27-46 (month) (day) (year)
(c) Cemetery or crematory Location Westam Conn Balto Md

18 (a) Funeral director Bernard C Hayes
(b) Address 121 E Lloyd St

19 (a) [illegible] SEP 26 1946 Huntington Williams, M.P. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25, 1946, at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1946, to Sept 25 1946 and that I last saw him alive on Sept 25 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Dehydration	
Due to Enteritis acute, Colitis acute.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Ileitis + colitis acute

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bons Secours Hosp. Balto. Md. Date signed 9-25-46

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44053 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Rolling Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary C. Wimmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 1 1862

8. AGE: Years	Months	Days	If less than one day
84	5	25	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Dec. Geo Dull

13. Birthplace Balto Md

MOTHER 14. Maiden Name Dec. Not Known

15. Birthplace

16 (a) Informant Mrs John F Mesz

(b) Address 104 Rolling Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28-46 (month) (day) (year)

(c) Cemetery or crematory David Ridge

Location Pikesville Md

18 (a) Funeral director Mrs Chas A G Rohde

(b) Address 2327 Edmondson Ave

19 (a) SEP 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/ 1946 at 3 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Cardiac failure Duration

Due to Arteriosclerosis Cardiac Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald M. Murphy M. D.

Address Stayer Date signed

VS 150

G44054

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1164a

G44054 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 S. Potomac St.
(c) Hospital or institution: City
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. Potomac (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Solomon Goldstrom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Genevieve

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1892

8. AGE: Years	Months	Days	If less than one day
54	4	14	3 hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Goldstrom

13. Birthplace —

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant Marie Rogers

(b) Address 2880 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25/46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave

18 (a) Funeral director John A. Ogston

(b) Address 3600 E. Baltimore St.

19 (a) SEP 26 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/46 19 , at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Strangulation

Due to Clothes line around neck

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9/25/46 at 7:00 P.M.

(b) Where did injury occur? 103 - Potomac

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Self inflicted

23. Signature John [illegible] M.D. Medical Examiner.

Date signed 9/26/46

TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please state the causes of death clearly and legibly.

644055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 121

644055

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Pt. Balto-19
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 F Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Morgan Brown

3 (b) If veteran, name war: World I
3 (c) Social Security Account No. 213-07-3446

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17 1889

8. AGE: Years 57 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Blk Bate Foreman

11. Industry or business

FATHER
12. Name John Morgan Brown
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Rudy
15. Birthplace Pennsylvania

16 (a) Informant Wife
(b) Address 613 F. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/46 (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belair Rd.

18 (a) Funeral director John. A. Moran
(b) Address 3600 E. Balto. St.

19 (a) SEP 26 (Date rec'd by registrar) (b) 1946 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1946, at 1 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21, 1946 to Sept 25, 1946 and that I last saw him alive on Sept 25, 1946.

	Duration
Immediate cause of death: Gen. septicemia	4 Plus +
Due to: Gen peritonitis	72 hrs +
Due to: Ruptured appendix	
Other Conditions: Mild diabetes mellitus (Include pregnancy within 3 months of death)	

Date of operation Sept 21, 1946
Major findings of operation: Ruptured appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wayne N. Jacobus, M.D. M. D.
Address Church Home & Hosp. Date signed 9/25/46

VS 150

G44056 DCH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. D49782 104183 119a

Registered No. G44056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Harry~~ BARRY Theodore Lindsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21/1946

8. AGE: Years	Months	Days	If less than one day
	3	22 0	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name DeFarney Lindsay
13. Birthplace Maryland

MOTHER
14. Maiden Name Marion Hairston
15. Birthplace Va.

16 (a) Informant Baltimore Maryland
(b) Address 4940 Eastern Ave (Records

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept. 23-1946 (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) Date received by registrar SEP 27 1946 (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21st 1946, at 8.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31/ 1946 to Sept 21 1946, and that I last saw him alive on Sept 21/1946

Immediate cause of death	Duration
Bronchopneumonia	2da
Due to malnutrition	3wks
Due to Diarrhea	4wks
Other Conditions Prematurity	Life

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Prematurity, Bronchopneumonia, malnutrition

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson E. Hughes
Address Balto City Hosp Date signed Sept. 27

(over)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

644057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 47c

Registered No. 644057

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County ? York
(c) City or town Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Baltimore St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M. Ruby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Mrs. Harry M. Ruby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1884

8. AGE: Years	Months	Days	If less than one day
61	10	10 9	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business Business

FATHER
12. Name George Ruby (D)
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Miller (D)
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address 33rd & Colvert Sts, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Hanover Pa

18 (a) Funeral director W. A. Fesser
(b) Address Hanover, Pa

19 (a) SEP 26 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1946, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1946, to Sept. 26 1946, and that I last saw him alive on Sept. 26 1946.

Immediate cause of death: Cerebral Metastases — Duration

Due to Bronchogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9/21/46 (biopsy)
Major findings of operation: Metastases in cervical lymph node
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. V. Hurley, M.D. M. D.
Address UMH Date signed 9/26/46

X

G44058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1310

G44058

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE FLEMING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife Chas. A Fleming
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1882

8. AGE: Years	Months	Days	If less than one day
63	11	27	hr. min.

9. Birthplace Carroll Co Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter Dellman
13. Birthplace Md.

MOTHER
14. Maiden Name Edith A. Franklin
15. Birthplace Md.

16 (a) Informant Chas. A. Fleming
(b) Address Woodbine Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-46 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Winfield Carroll Co. Md.

18 (a) Funeral director C. M. Watts
(b) Address Winfield Md

19 (a) Date received SEP 27 1946 (b) by Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1946, at 9.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to Sept 24 1946, and that I last saw h alive on Sept 24 1946.

Immediate cause of death	Duration
Arteria Sclerotica C.V Renal Lesions	
2 Cerebral Vascular Accident	
Due to 3 Bronchopneumonia	
4 Mitral Valve Deformity	
Due to 5 Auricular Fibrillation	
6 Pyelonephritis Chronic	
Other Conditions 7 Intoxication	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R E Bauer M. D.
Address University Hospital Date signed 9-27-46

VS 150

644059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. 644059

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Norway Lowdens
(c) City or town 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Norway

3 (a) FULL NAME Ivar Vogbugt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1902

8. AGE: Years	Months	Days	If less than one day
43	9	10	hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Steward.

11. Industry or business SS Vestrongen

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Norwegian Consulate
(b) Address

17 (a) Cremation (b) Date thereof 10/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Baltimore

18 (a) Funeral director Wm Cook, Inc.
(b) Address 1217 St Paul St

19 SEP 27 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1946, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary disease
Arteriosclerosis
Hypertrophy + dilatation of heart
Due to Aneurysm of left ventricle

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 9-26-46

VS 181

Physicians: Please write the causes of death clearly and legibly. Cause of death may be entered in part (a) and/or (b) as well as (c). Indicate clearly cause, if any, which gave rise to the immediate cause (a), stating the underlying cause last. Part (b) should be used to report other significant conditions contributing to death but not related to the disease or condition causing it. Please write in ink. Please answer all questions. Be sure that the information given for items 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 is complete and correct. Accurate and complete information is necessary to identify correctly the certificate. Exact age is especially important.

G44060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V122a

G44060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway 26-10
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N Bouldin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Froehlich.

3 (b) If veteran, name war: None.
3 (c) Social Security Account No.: None.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. E. Froehlich.
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Sept 12, 1887

8. AGE: Years	Months	Days	If less than one day
59	0	13	hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Pattern Maker.
11. Industry or business Foundry Molder.

FATHER
12. Name John Froehlich
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Everhart
15. Birthplace Balto.

16 (a) Informant Mrs Froehlich
(b) Address 502 N Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md
18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1946, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946, to Sept 25 1946, and that I last saw h[illegible] alive on Sept 24 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary thrombosis	
Due to Arteriosclerosis	
Other Conditions Recurrent hernia, L.	

(Include pregnancy within 3 months of death)
Date of operation 5 September 46
Major findings of operation: Recurrent hernia, L.
of autopsy: Coronary thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John A Ponni M. D.
Address Church Home & Hospital Date signed 28 Sept 46

VS 180

G44061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43E

G44061 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-1
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arnold Holtgreafe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11-1935

8. AGE: Years	Months	Days	If less than one day
11	8	14	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation Student

11. Industry or business St. Patrick's School

FATHER 12. Name Arnold Holtgrafe

FATHER 13. Birthplace Baltimore - Md

MOTHER 14. Maiden Name Jennie Przybylowski

MOTHER 15. Birthplace Balto. Md

16 (a) Informant Jennie Holtgrafe

(b) Address 1922 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Rd

18 (a) Funeral director Selby & Zeller Inc

(b) Address 413 S. Hoyt St.

19 (a) Date received by registrar SEP 27 1946 (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1946, at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive cardiac failure

Due to

Other Conditions Edema & Congestion of lungs & all other viscera (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Thomas J. Mercein M.D. Medical Examiner

Date signed 9-26-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G44062
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 13-1
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Brookfield (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie Lion

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 15, 1875

8. AGE: Years	Months	Days	If less than one day
70	9	10	hr. min.

9. Birthplace Warrenton, Va. (Town, county, and state)
10. Usual Occupation Nurse (retired)
11. Industry or business

FATHER
12. Name Louis Lion
13. Birthplace Germany

MOTHER
14. Maiden Name Hanna Block
15. Birthplace Balto., Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 27 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1946 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1946 to Sept. 25 1946 and that I last saw h alive on Sept. 25 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A.M. Knight M. D.
Address J. H. H. Date signed 9-25-46

VS 150

G44063

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ X 12/a

G44063
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmont Ave
(c) Hospital or institution:
Parkmont Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Raspeburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 Ridgeway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Schiller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Bernard Schiller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/6/1861

8. AGE: Years	Months	Days	If less than one day
84	11	20	hr. min.

9. Birthplace Balto. Co. Md
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Wheeler
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Anna Pisney
15. Birthplace Balto. Co. Md.

16 (a) Informant Walter C. Schiller
(b) Address 4608 Ridgeway Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 30 46 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director Lasasha Funeral Home
(b) Address 9401 Belair Rd
Huntington Williams Registrar

19 (a) (b)
SEP 27 1946

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26th 1946 at 5:- P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to Sept 26 1946, and that I last saw h[illegible] alive on Sept 26 1946.

Immediate cause of death Terminal Pneumonia — Duration 10 days
Due to Chronic myocarditis
Due to Chronic nephritis
Other Conditions Arteriosclerosis Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Walter A Anderson M. D.
Address 300 N Shannon Dr Date signed Sept 27-46

Dead Letter

G44064 2-57710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1611a

G44064
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janice Marie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1946

8. AGE: Years | Months | Days | If less than one day: 15 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Walter Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Virginia Robinson
15. Birthplace Baltimore, Md.

16 (a) Informant J W Smith
(b) Address Belair Rd + Slade ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-46 (month) (day) (year)
(c) Cemetery or crematory Lassahn B Grd
Location 7401 Belair Road

18 (a) Funeral director Lassahn Funeral Home
(b) Address Baltimore 6 Md

19 (a) (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1946, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1946 to Sept. 25 1946, and that I last saw her alive on Sept. 25 1946.

Immediate cause of death: Atelectasis — Duration:

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry T. Nelson Jr.
Address St. Joseph Hospital Date signed 26 Sept 46

X

Birth Certificate

G44065 J-57709 BALTIMORE CITY HEALTH DEPARTMENT X G44065

CERTIFICATE OF DEATH √161a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 391/4 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanne Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 25, 1946

8. AGE: Years	Months	Days	If less than one day
		1	15 hr. 15 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Walter Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Virginia Robinson
15. Birthplace Baltimore

16 (a) Informant J. W. Smith
(b) Address Belair Rd & Hazel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-46 (month) (day) (year)
(c) Cemetery or crematory Lassahn B. Rod
Location 7401 Belair Road

18 (a) Funeral director Lassahn Funeral Home
(b) Address Baltimore, Md.

19 (a) SEP 27 1946 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1946, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1946, to Sept. 26 1946, and that I last saw h er alive on Sept. 26 1946.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
M. Signature Harry J. Wilson, Jr. M. D.
Address St. Joseph's Hosp Date signed Sept 26

VS 150

G44066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

Register No. G44066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2054
(b) Street address Wilkens + Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3520 Emerson St. Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Henry C. Rothenhoefer ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4521

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 25 Aug. 1877

8. AGE: Years	Months	Days	If less than one day
69	0 1	29	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Henry Rothenhoefer
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Finkler
15. Birthplace Germany

16 (a) Informant Miss Martha P. Rothenhoefer
(b) Address 3520 Emerson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 29 Sept. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director P. B. Shipley + Sons
(b) Address 1300 Eutaw Place

19 SEP 27 1946 Curtis Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1946, at 1:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1946 to 9/27 1946 and that I last saw him/her alive on 9/24 1946

Immediate cause of death Cerebral Embolism
Consecutive to Thrombosis
Antecedent Cardiac Disease

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [signature] Date signed

X

G44067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G44067
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden 1505
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County –
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Liberty Heights Ave.
(If non-private location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Kahn M.D.

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Florence R.

6 (c) If alive, give age 1877 years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	9	726		

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Dr of Medicine

11. Industry or business Physician

FATHER
12. Name Meyer Kahn
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Mayer
15. Birthplace Germany

16 (a) Informant Mrs. Florence R. Kahn
(b) Address 2513 Liberty Hgts. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/46 (month) (day) (year)
(c) Cemetery or crematory Obel Shalom
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1903 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1946 at 6 02 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1946 to 9/24 1946 and that I last saw h[illegible] alive on 9/24 1946.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Coronary Arteriosclerosis	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? –
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. Mitchell
Address Balt. Gen. Hosp. Date signed 9/27/46

(over)

94a

G44068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1131a

Registered No. G44068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Argyle Ave.
(c) Hospital or institution: 1742
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CLIFTON B. HENSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Letitia Henson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1877

8. AGE: Years	Months	Days	If less than one day
68	10	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name John Henson
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Todd
15. Birthplace Md.

16 (a) Informant Mrs. Letitia Henson
(b) Address 1120 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-46 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

SEP 27 1946 (b)
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 26 1946 at 12:30

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20 1946 to 9/26 1946, and that I last saw h[illegible] alive on 9/26 1946.

Immediate cause of death: Hypertensive Cardio Renal Disease — Duration: 3 mos
Due to: Hypertension
Due to:
Other Conditions: Nephritis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address 1243 Penna. Ave Date signed 9/27/46

VS 150

Huntington Williams, M.D.

X

G44069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G44069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 Christopher Ave
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Christopher ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Catherine Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Thomas W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-1882

8. AGE: Years	Months	Days	If less than one day
63	10	8	hr. min.

9. Birthplace Wayford Co Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Simpson
13. Birthplace

MOTHER
14. Maiden Name Sarah ?
15. Birthplace

16 (a) Informant Thomas W. Clark
(b) Address 2820 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-26 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director R. J. Pangle
(b) Address 5315 Wayford Rd

19 9-27-1926 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25-26 19 at 2:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1925 to 9-25-26 19 and that I last saw h alive on 9-25-26 19

Immediate cause of death Terminal
Bronchopneumonia
Due to Metastatic carcinoma of Lung
Due to Epithelial metastatic [illegible]
tion Radical mastectomy of
Other Conditions right breast

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3½ yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. J. Pangle
Address 642 Wash Blvd Date signed 9-27-26

VS 150

R. J. Pangle X

G44070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G44070 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-W
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. # 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Harlem Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Alelia Powe

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Doc. Powe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1911

8. AGE: Years	Months	Days	If less than one day
35	4	25	hr. min.

9. Birthplace So. Carolina (Town, county, and state)
10. Usual Occupation Lowfe
11. Industry or business

FATHER
12. Name Samuel Spencer
13. Birthplace N. Ca.

MOTHER
14. Maiden Name Emily Johnson
15. Birthplace No. Ca.

16 (a) Informant Samuel Spencer
(b) Address 1308 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

SEP 27 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25 1946, at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1946 to 9-25 1946, and that I last saw h. alive on 9-25 1946

Immediate cause of death	Duration
Cardio vascular-respiratory failure	
Due to Chronic Glomerular Nephritis	
Due to Hypertensive cardio vascular renal disease	
Other Conditions Pneumonia, carditis, aortic dilitation, anemia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. A. Shallenberger M.D.
Address University Hospital Date signed 9-27-46

VS 150

G44071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G44071 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6602 Fair Oaks Ave
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6602 Fair Oaks Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John S. Whelchel

3 (b) If veteran, name war: 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	W

6 (b) Name of husband or wife Eva Cles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-8-1874

8. AGE: Years	Months	Days	If less than one day
72	4	18	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Aaron Whelchel
13. Birthplace Ga.

MOTHER 14. Maiden Name Rachel Pierce
15. Birthplace Ga.

16 (a) Informant Mrs. P. T. Whiting
(b) Address 6602 Fair Oaks Ave

17 (a) Transit (Burial, cremation, or removal) (b) Date thereof 9-27-46 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cem
Location Hoper Ga.

18 (a) Funeral director L. J. Kupp
(b) Address 5315 Harford Rd

SEP 27 1946 (Date rec'd by Registrar) (c) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1946 at 10.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1946 to Sept 26 1946 and that I last saw h[illegible] alive on July 5 1946.

Immediate cause of death
Coronary thrombosis
Arteriosclerotic cardiovascular
Due to Renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 87th hour
3 mos.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause by which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 6217 Harford Rd Date signed 9/27/46

To be approved by C. M. E. H. J. Mackin, M.D.

G34072 Vol 11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. G34072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 N. Fulton Ave.
(c) Hospital or institution: 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aloysius H. Voll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Julia Saunders 6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1868

8. AGE: Years	Months	Days	If less than one day
78	7	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Germany

MOTHER
14. Maiden Name Virginia Whaley
15. Birthplace Va.

16 (a) Informant Mrs. Julia Voll
(b) Address 1525 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Bakey & Sons
(b) Address 1827 W. North Ave.

19 (Date rec'd by registrar) SEP 27 1946 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 26 1946, at 8°2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 20 1946 to SEPT 26 1946, and that I last saw him alive on SEPT 26 1946.

	Duration
Immediate cause of death: CORONARY THROMBOSIS	1 DAY.
Due to GENERALIZED ARTERIOSCLEROSIS	15 yrs
Due to	
Other Conditions ULCERATIVE COLITIS	8 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman R Kleeman M. D.
Address 3803 Edmondson Date signed 9/26/46

Kleeman X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44073 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3212 Avon Ave
(c) Hospital or institution: 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Avon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Thim

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29 1869

8. AGE: Years	Months	Days	If less than one day
76	11	27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Keeper (Retired)

11. Industry or business

FATHER
12. Name John B. Thim
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Nagle
15. Birthplace (?)

16 (a) Informant Miss Barbara Thim
(b) Address 3212 Avon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-46 (Month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belgel Rd.

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt. St.

19 (a) (Signature of registrar) (b)
SEP 27 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Sept., 1946, to 27 Sept 1946, and that I last saw her alive on 27 Sept. 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 hrs
Due to Upper thoracic, arteriosclerotic Cardiovascular disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Rd. Date signed 9/27/46

G44074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 121 B

G44074
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 N. Dallas
(c) Hospital or institution: 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 N. Dallas
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen E. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Robert I.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1872

8. AGE Years	Months	Days	If less than one day
74	4		hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Kehm
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Farrell
15. Birthplace Ireland

16 (a) Informant John Baker
(b) Address 1807 N. Dallas St.

17 (a) BURIAL (b) Date thereof 9/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location NORTH AVE & ROSE ST

18 (a) Funeral director CLARENCE F. HOFFMAN
(b) Address 1639 BROADWAY

19 (a) ~~Sept 27 1946~~ Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1946 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10, 1945 to Sept. 26 1946 and that I last saw her alive on Sept. 26, 1946.

Immediate cause of death

Uremia & Anasarca — Duration 1 wk
Due to Chronic Myocarditis and Chronic Nephritis — 2 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ernest Lewis MD
Address 1641 N. Broadway Date signed 9/26/46 M.D.

G44075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164

Registered No. G44075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-2
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 265- N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ULYSSUS GAMBLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Silver St. S.C. (Town, county, and state)

10. Usual Occupation Fairfield Shipyard

11. Industry or business

FATHER
12. Name Boston Gamble
13. Birthplace S.C.

MOTHER
14. Maiden Name Lizzie Gantly
15. Birthplace S.C.

16 (a) Informant Watenlla Tindal
(b) Address 309 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27. 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomtty ave

19 (a) 9 27 1946 (Date rec'd by registrar) (Huntington Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1946 at 12.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure
Acute Congestion of Lungs
Due to

Other Conditions Arteriosclerosis of brain & all other viscera.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 9-22-46 at 12.15 a. M.
(b) Where did injury occur? Low & Colvin St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Blunt Force

23. Signature Howard J. Alessio M.D.
Medical Examiner.
Date signed 9-23-46

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G44076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Oakmont Ave
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Oakmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Elizabeth Corbin

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Joshua M. Corbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7 1879

8. AGE: Years 67 | Months 6 | Days 20 | If less than one day: hr. min.

9. Birthplace Carroll Co. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harrison Davis
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Sarah Ellen Parish
15. Birthplace Carroll Co

16 (a) Informant Joshua M. Corbin
(b) Address 3510 Oakmont Ave Balto Md

17 (a) Burial, cremation, or removal (b) Date thereof Sept 29-46 (month) (day) (year)
(c) Cemetery or crematory Dew Park
Location Carroll Co.

18 (a) Funeral director J. F. Gluns Sons
(b) Address Westminster Md

SEP 27 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27-46, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-39 19 to 9-27-46 19, and that I last saw h[illegible] alive on 9-26-46.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Gaffell M. D.
Address Westminster Date signed

VS 150

x 9/27/46

G44077 BALTIMORE CITY HEALTH DEPARTMENT G44077

CERTIFICATE OF DEATH 95B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 da
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Niva Downes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-28-92

8. AGE: Years	Months	Days	If less than one day
54 55	-	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Reggin
13. Birthplace Maryland

MOTHER
14. Maiden Name Jobise Sterling
15. Birthplace ?

16 (a) Informant Deceased
(b) Address 1412 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Loony Ridge
Location Emmitsburg Md

18 (a) Funeral director Howard Hubbard
(b) Address Oisfield, Md.

19 (a) SEP 27 1946 Registrar
(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 19 , at 10:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1946 to 9-26 1946, and that I last saw her alive on 9-26 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	—
Due to Chronic congestive heart failure	
Due to Rheumatic heart disease (?)	3 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
73. Signature Robert E May M.D.
Address Calvert + Saratoga Sts Date signed 9-26-46

G44078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √99

G44078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Gwynns Falls Pkwy.
(c) Hospital or institution: 15-6.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY S. BLAKE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Curtis Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1870

8. AGE: Years	Months	Days	If less than one day
76	1		hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christopher C. Speed
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary E. Munna
15. Birthplace Balto., Md.

16 (a) Informant Mr. Wm. G. Speed, Jr.
(b) Address 227 St. Paul Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 27 1946 (Date rec'd by registrar) Huntington Williams M.D. (b) Address

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1946, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1946, to 9/26, 1946 and that I last saw h alive on 9-26 1946

Immediate cause of death: Shock - Hemorrhage Cellulitis of neck

	Duration
Due to Intestinal Obstruction	one day
Due to Mesenteric Thrombosis (?)	one day
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice E. Shannon M. D.
Address 3300 N. Howard Date signed 9/27/46

G44079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4813 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 83

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4813 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emily Augusta Siquot

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Camille Marcel Siquot
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) August 24, 1859

8. AGE: Years	Months	Days	If less than one day
87	1	2	hr. min.

9. Birthplace Oxford, Talbot Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Carl August Wagner
13. Birthplace Stuttgart, Germany

MOTHER
14. Maiden Name Pamelia Mister
15. Birthplace Somerset Co., Md.

16 (a) Informant Mr. Camille Marcel Siquot
(b) Address 4813 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Miles L. Amoss
(b) Address 4510 Liberty Heights Ave.

19 (a) Filed (Date of receipt) (b) Registrar Huntington Williams M.D.

SEP 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1946, at 12.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept. 26 1946, and that I last saw her alive on Sept. 25 1946, at

Immediate cause of death	Duration
(a) Arteriosclerotic Heart Disease.	7 yrs.
Due to	
Due to	
Other Conditions - Generalized Arterio-Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operations: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hgts Ave. Date signed

G44080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

Registered No. G44080

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 Frederick Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard F. Burke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lustus (Lucky) Burke
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) September 2, 1903

8. AGE: Years	Months	Days	If less than one day
43	-	24	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation Dispatcher
11. Industry or business Baltimore Motor Coach Co.

FATHER
12. Name Leonard F. Burke
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mary E. Ritter
15. Birthplace Woodlawn, Md.

16 (a) Informant Mrs. Mary E. Riechert
(b) Address 2028 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Wilkes Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) Date received (b) Registrar Huntington Williams, M.D.

SEP 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1946, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1946 to Sept 26 1946 and that I last saw him alive on Sept 26 1946.

Immediate cause of death: Carcinoma (Rectum) — Duration 1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Kelly M. D.
Address 3517 Edmondson Ave. Date signed

VS 150

X

The G44081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44081 Registered No. 1246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 W. University Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town) Catonsville Md
(d) Street No. 112 W. University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth K. Seager

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Edward V. Seager

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st 1885

8. AGE: Years	Months	Days	If less than one day
61	3	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Joseph B. Kent
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Curlett
15. Birthplace Balto. Md.

16 (a) Informant Edward V. Seager
(b) Address 112 W. University Pkwy

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 9/28/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount Mausoleum
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by Reg. SEP 28 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26th 1946, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Sept 26 1946, and that I last saw her alive on Sept 26 1946.

Immediate cause of death: Portal cirrhosis (7 Liver) — Duration: 5 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel Whitehouse M. D.
Address 1729 Eutaw Pl. Date signed Sept 27/46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44082

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G44082

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 Rayner Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Rayner Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie B. Plummer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Sidney Plummer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1868

8. AGE: Years 78 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Wm A. Anderson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amanda Hall
15. Birthplace Balto. Md.

16 (a) Informant Lillian Germac
(b) Address 2934 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 28 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26th 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1946 to 9/26 1946 and that I last saw h[illegible] alive on 9/26 1946.

Immediate cause of death

	Duration
Arteriosclerotic Heart Disease	7 years
& Coronary Failure	5 days
Due to Hemiplegia-Left	2 days
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Coleman M.D.
Address 1201 Eyler Ave Date signed 9/27/46

VS 150

G44083

Chovanec

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G44083
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Callow Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Clara Chovanec

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rudolph Chovanec

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1895

8. AGE: Years 51 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Shmuybrook
13. Birthplace Baltimore

MOTHER
14. Maiden Name Jane Unknown
15. Birthplace Baltimore

16 (a) Informant Rudolph Chovanec
(b) Address 2101 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Wm. Cookingham
(b) Address 217 St Paul St. Balto

19 (a) Filed (Date received by registrar) Sep 30 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1946 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1946 to Sept. 26, 1946 and that I last saw h[illegible] alive on Sept. 26, 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Toby M.D.

Address West Balto Gen. Hosp. Date signed 9/26/46

VS 150

G44084
TH.

BALTIMORE CITY HEALTH DEPARTMENT
104318 CERTIFICATE OF DEATH 186a Registered No. G44084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Beltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2644 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Riecke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26th. 1859

8. AGE: Years 87 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name John Kohler
13. Birthplace Germany

MOTHER
14. Maiden Name Frederick (Unknown)
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) SEP 28 1946 (Date rec'd by registrar) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27th 1946 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5/1946 to Sept 27 1946 and that I last saw her alive on Sept 27/ 1946

Immediate cause of death Arteriosclerotic Heart Disease, & Myocardial failure — Duration

Due to

Due to

Other Conditions Intertrochanteric Fracture, Rt. Femur — 4 weeks

(Include pregnancy within 3 months of death)

Date of operation 9-18-46

Major findings of operation: Intertrochanteric fracture, rt. femur.

of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 5 1946 at subway
(c) Where did injury occur? 4940 Eastern Ave Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Manner of injury Tripped & Fell at home

23. Signature Marvin M. Lang
Address Baltimore City Hosp Date signed 9-28-46 M. D.

VS 150

Homer J. Mancini, M. D. X

G44085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 W Pratt St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 04
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 W Pratt St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Libby Hellwig

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Otto J. Hellwig
6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): March 6 1874

8. AGE: Years 72 | Months 6 | Days 21 | If less than one day: hr. ___ min. ___

9. Birthplace: Illinois (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: none

FATHER
12. Name: L. S. Libby
13. Birthplace: Maine

MOTHER
14. Maiden Name: Amanda Jernigan
15. Birthplace: Illinois

16 (a) Informant: Mr O. J. Hellwig - Husband
(b) Address: 416 W Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-30-46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: Sherwood Mortuary
(b) Address: 108 W Monument

19. Date received by Local Registrar: SEP 28 1946 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4- 1946, to 9-27 1946, and that I last saw h.er alive on 9-20 1946.

Immediate cause of death	Duration
Acute Heart failure	1 hour
Due to Arteriosclerotic Heart Disease	9 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: L. Harris Pearce M. D.
Address 312 Medical Arts Bldg Date signed 9-27-46

G44086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G44086 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D/A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1898

8. AGE: Years	Months	Days	If less than one day
47	9	29	hr. min.

9. Birthplace West Va. (Town, county, and state)

10. Usual Occupation Machinist helper

11. Industry or business B. & O. R. R.

FATHER
12. Name U. S. Watson
13. Birthplace W. Va.

MOTHER
14. Maiden Name Florence Johnson
15. Birthplace Va.

16 (a) Informant Margie A. Davis
(b) Address 112 S. Calhoun Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 1946 (month) (day) (year)
(c) Cemetery or crematory Balto. V. S. National
Location

18 (a) Funeral director Joseph C. B. McWalter
(b) Address 1411 Hatt. Stricker St

SEP 28 1946 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1946, at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. H. Schmitz M.D. Medical Examiner.
Date signed 9/30/46

VS 191

G44087

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92c

G44087 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2-2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. 41st Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Barnhart

3 (b) If veteran, name war: Mexican Border
3 (c) Social Security Account No. 218-03-0379
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: Mary E. Barnhart
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 12-1892
8. AGE: Years 54 Months 1 Days 14 If less than one day hr. min.
9. Birthplace Carroll Co. Maryland (Town, county and state)
10. Usual Occupation Carpenter
11. Industry or business
FATHER 12. Name John Barnhart
13. Birthplace Maryland
MOTHER 14. Maiden Name Mary
15. Birthplace Maryland
16 (a) Informant Mrs. Mary E. Barnhart
(b) Address 1314 N. 41st Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30. 1946 (month) (day) (year)
(c) Cemetery or crematory Reisterstown
Location Manchester, Carroll Co. Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) SEP 28 1946 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1946 at 5-50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from January 12 1946, to Sept 26 1946 and that I last saw him alive on Sept 26 1946

Immediate cause of death: Cong. Heart Failure — Duration 2 Days
Due to Rheumatic Heart Disease — 5 years
Due to Mitral Stenosis Cardiac
Other Conditions Hypertrophy & dilatation
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Leonard Wallenstein
Address 818 W 36 St Date signed 9/27/46 M. D.

VS 150

G44088 BCH F25790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 64

Registered No. G44088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Buena Vista Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Russell Smith, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1941

8. AGE: Years	Months	Days	If less than one day
5	6 5/29	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Lawrence Russell Smith
13. Birthplace Maryland

MOTHER 14. Maiden Name Wanda June Burgee
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 323 Falls Road

19 SEP 28 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 I. Approved by ME

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1946 to Sept 27 1946 and that I last saw him alive on Sept. 27 1946.

Immediate cause of death	Duration
Pneumothorax, bilateral	30 min
Due to	
Due to	
Other Conditions Status Thymo Lymphaticus	life

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy
Major findings of operation: emergency
of autopsy Status Thymolymphaticus

PHYSICIAN Underline the cause to which death should be charged, stating

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard J. Mercer, M.D.
Address Date signed 9-27-46

Howard J. Mercer, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No. C44089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

Registered No. C44089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs!

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 11 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Oakington St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Rose Virginia Chalk

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John H Chalk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1872

8. AGE: Years	Months	Days	If less than one day
74	2	24	- hr. - min.

9. Birthplace (City or county, and state) Balto Co. Maryland

10. Usual Occupation At Home
11. Industry or business

FATHER — 12. Name	Joshua Gill
FATHER — 13. Birthplace	Maryland
MOTHER — 14. Maiden Name	Sarah —
MOTHER — 15. Birthplace	Maryland

16 (a) Informant John M. Chalk.
(b) Address 2003 Oakington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 29-1946 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Harrisville Baltimore Co. Md.

18 (a) Funeral director Durgin Funeral Home
(b) Address 3491 Falls Road

19 (a) SEP 28 1946 (b) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1946, at 10 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1946 to 9/26 1946, and that I last saw her alive on 9/26 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary Edema	
Due to Cardiac failure	
Other Conditions Lobar Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Mitchell
Address Bnd. Gen Hosp. Date signed 9/26/46

111 C

G44090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G44090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 953 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 953 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maud

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1888

8. AGE: Years 58 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Maude Williams
(b) Address 953 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cems
Location A.A. County Md

18 (a) Funeral director Mo. Robt. E. Elliott & Co
(b) Address 1129 N. Caroline St

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

SEP 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1946, at 11: A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1946, to Sept. 25 1946, and that I last saw him alive on Sept. 25 1946.

	Duration
Immediate cause of death: Bilateral lobar pneumonia Type III	8 da
Due to grippe	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 937 N. Caroline St. Date signed 9-26-46

X

G44091 SUCHANEK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G44091 Registered No.

PLEASE WRITE PLAINLY. WITH INK. DO NOT ERASE. Every item of information should be carefully checked and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 85 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 E Madison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA SUCHANEK (NEE PRYBORSKI)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ADOPH FRANK SUCHANEK

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 7/25/79

8. AGE: Years 67 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace CZECHOSLOVAKIA (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank NEMEC

13. Birthplace CZECHOSLOVAKIA

MOTHER 14. Maiden Name Maria Kobat.

15. Birthplace CZECHOSLOVAKIA

16 (a) Informant HENRY SUCHANEK-SON

(b) Address 2827 E. MADISON ST.

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof SEPT 28, 1946 (month) (day) (year)

(c) Cemetery or crematory Greenmount Crematory

Location Greenmount Ave.

18 (a) Funeral director A. Schimmel

(b) Address 2601-638 Madison Street

19 (a) SEP 28 1946 (Date rec'd by registrar) Huntingtown, Millsboro, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/46 19 at 1.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18/46 19 to 9/25/46 19 and that I last saw h[er] alive on 9/25/46 19

Immediate cause of death: carcinomatosis & cachexia — Duration

Due to: Carcinoma of sigmoid

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/2/46

Major findings of operation: Carcinoma of sigmoid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Worth Jr.

Address Bon Secours Date signed 9/25/46

VS 150

G44092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44092 Registered No.

T.N. 104613

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 W. Woodwell Rd. Dundalk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Kandel

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Kandel
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec. 23rd 1875

8. AGE: Years	Months	Days	If less than one day
70	9	1	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Coal Miner
11. Industry or business Retired

FATHER
12. Name John Kandel (D
13. Birthplace Poland

MOTHER
14. Maiden Name Rosie (D
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Sept. 28. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Christ Ev. Luth. Ch. Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (Date received by Registrar) SEP 28 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH September 24 th 19 46 at 11.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19th 1946 Sept 24 1946 and that I last saw h im alive on Sept 24 1946

Immediate cause of death	Duration
Cardio respiratory failure.	
Due to Astero-selerotic cardio-vascular disease, and	
Due to Silicosis and bronchial asthma.	
Other Conditions Benign prostatic hypertrophy with urinary retention	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. F. Zeller
Address Balt. City Hospitals Date signed 9/27/46

G44093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44093 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 754 Reservoir Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 754 Reservoir Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE ELIZABETH MYER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/65

8. AGE: Years	Months	Days	If less than one day
81	0	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Marshall Myer
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret Jane Filberg
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr Charles Myer
(b) Address 754 Reservoir Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore, Md

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert Street

19 SEP 28 1946 Huntington Williams, M.D. (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1946 to Sept 27 1946 and that I last saw h alive on Sept 22 1946.

Immediate cause of death	Duration
Heart collapse	7 days
Due to Cerebro-vascular disease	6-7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Brennan Stood M. D.
Address 2200 Guilford Blvd Date signed 9/28/46

G44094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. G44094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 Douglas Court (If rural give location)
(e) Citizen of foreign country? N/D (Yes or No) If yes, name country

3 (a) FULL NAME Benj Melvin

3 (b) If veteran, name war 2 | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1880

8. AGE: Years	Months	Days	If less than one day
66	5	3	hr. min.

9. Birthplace Portsmouth Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Calvin Melvin
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Hannep
15. Birthplace Virginia

16 (a) Informant Mat Kelly
(b) Address Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery [redacted] Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Charles Alexander
(b) Address 1300 Mc Culloh St.

SEP 28 1946 (Date received by Local Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1946 19 46 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Sept 21 1946, and that I last saw h alive on Sept 21 1946

Immediate cause of death: Cardio Respiratory Failure. — Duration

Due to: Cerebral Vascular Accident. —

Due to: Hypertensive vascular disease. —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wells M. D.
Address 1 St Jos Way Date signed 9-27-46

VS 150

G44095 G44095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1124a

CHK-104750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35- 9- 14-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6513 Glenoak Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Cronhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arthur J. Cronhardt
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Dec. 13-1910

8. AGE: Years	Months	Days	If less than one day
35	9	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Howard Harman
13. Birthplace Maryland

MOTHER
14. Maiden Name Cora Gieman
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 9-30-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Westminster, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

SEP 29 1948 (b) Huntington Williams, Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946 at 11:38 A

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1946 to Sept. 27 1946 and that I last saw her alive on Sept. 27 1946

Immediate cause of death: Pneumonia, Hypostatic — Duration: 3 days

Due to Alcoholism, Chronic

Due to

Other Conditions Hepatitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy AUTOPSY Pneumonia, hypostatic with Cirrhosis, atrophic, Fatty degeneration of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 9-27-46

3991 G44096

BALTIMORE CITY HEALTH DEPARTMENT X G44096

CERTIFICATE OF DEATH ✓ 96

Registered No.

Every item of information should be carefully supplied. The exact age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Mason
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ira Bolyard

3 (b) If veteran, name war

3 (c) Social Security Account No. 236-12-1091

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie Bolyard
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) 5/30/1895 (1894)

8. AGE: Years	Months	Days	If less than one day
64 51	3	28	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Grant Bolyard
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary ? ?
15. Birthplace West Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/28/46 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Wm. J. Tiebner & Son
(b) Address No. 4 & Pa. Ave. Balt. 17 Md.

19 (a) [illegible] by registrar (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1946, to 9-28 1946, and that I last saw h[illegible] alive on 9-28 1946.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	3 weeks
Due to Cerebral Aneurysm ?	
Due to	
Other Conditions Hypertension Uraemia.	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation
of autopsy: Refused.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur M. Laing
Address Johns Hopkins Hosp. Date signed 9/28/46 M. D.

VS 150

(OCT) Kings X

G44097 BC# 499397. 905804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G44097 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 Reisterstown Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Gordon.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-46

8. AGE: Years	Months	Days	If less than one day
	1	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Irvin Gordon
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dorothy Mackenick
15. Birthplace Baltimore, Md.

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rodef Sholom
Location Pikesville

18 (a) Funeral director Sol Levinson + Bros
(b) Address 114-16 W. North ave

19 (a) 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1946, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1946, to Sept. 26 1946, and that I last saw him alive on Sept. 26 1946.

Immediate cause of death: DIARRHEA OF NEWBORN — Duration 3 days

Due to

Due to

Other Conditions PREMATURITY — LIFE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H Hardy M. D.
Address Johns Hopkins Hosp. Date signed 9/29/46

VS 150

G44098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G44098

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Pennington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE - BELBOT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1-1856

8. AGE: Years 90 | Months 6 | Days 7/30 | If less than one day hr. min.

9. Birthplace Poland

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Ziemiencki

13. Birthplace Poland

MOTHER 14. Maiden name Unknown

15. Birthplace Poland

16 (a) Informant Mrs. D. Stark

(b) Address 4700 Pennington Ave

17. Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Sept 30 46

(c) Cemetery or crematory Holy Cross

Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling

(b) Address 2014 Hanover St (26)

SEP 29 1946

(Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946, at 8:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1945 to Sept 27 1946 and that I last saw her alive on Sept 25 1946.

Immediate cause of death

Myocardial Insufficiency

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 8 mos. 2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Stark M.D.

Address 4700 Pennington Ave Date signed Sept 27 1946

G44099 BALTIMORE CITY HEALTH DEPARTMENT G44099

CERTIFICATE OF DEATH 49a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WRITE FIRMLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd
(c) Hospital or institution: Haven Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 DeSoto Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Duckett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband: Howard F. Duckett
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 1 1880
8. AGE: Years 66 | Months 8 | Days 1325 | If less than one day hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Henry Weaver
13. Birthplace: Balto

MOTHER
14. Maiden Name: Caroline Foy
15. Birthplace: Balto.

16 (a) Informant: Leroy A. Duckett
(b) Address: 1813 DeSoto Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.
18 (a) Funeral director: William Cook Sons.
(b) Address: 1217 St. Paul St
19 (a) Date received by Registrar (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26th 1946, at 11 23 A. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1946 to Sept 26 1946, and that I last saw h[illegible] alive on Sept 23 1946.
Immediate cause of death: Adeno carcinoma Left Ovary with general abdominal Metastases — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Aug. 1946
Major findings of operations: Adeno carcinoma
Laparotomy Aug 1946
of autopsy: (as above)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Carl P. Rostkind
Address 1316 W Lombard St Date signed 9/29/46 M. D.

VS 150

G44100 — BALTIMORE CITY HEALTH DEPARTMENT — G44100

500713

CERTIFICATE OF DEATH 467

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Abbottston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susan Kid Daley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-1865

8. AGE: Years 80 | Months 10 | Days 28 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Samuel Martin
13. Birthplace Md

MOTHER — 14. Maiden Name Elizabeth Bond
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

SEP 29 1946

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 26 1946, at 1025 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1946, to Sept. 26 1946, and that I last saw ~~him~~ her alive on Sept. 26 1946

Immediate cause of death Shock and respiratory failure — Duration 6 months

Due to Carcinoma of rectum c metastases to liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Sept 24, 1946
Major findings of operation: Carcinoma, rectum & metastases to liver
of autopsy ~~(if any)~~ none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry P. Porter M. D.
Address Johns Hopkins Hosp Date signed 9-27-46

G44101

BALTIMORE CITY HEALTH DEPARTMENT ✓ 50

CERTIFICATE OF DEATH

G44101
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3233 Burkith Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida Colton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph Colton
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 28, 1909
8. AGE: Years 36 | Months 11 | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Mandell
13. Birthplace Russia

MOTHER
14. Maiden Name Toby Ehrlich
15. Birthplace Russia

16 (a) Informant Joseph Colton
(b) Address 3233 Burkith Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad Rd & Hamilton Ave
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

(a) Date received SEP 29 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1946, at 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1946, to Sept 29 1946, and that I last saw him alive on Sept 28 1946.

Immediate cause of death: Coma - lung failure — Duration

Due to Generalized carcinomatosis — 18 mos.

Due to Carcinoma of Bronchus Elsion & Lung metastases — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1944
Major findings of operation: Carcinoma of bronchus, Rt - lateral
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature Howard Carr M. D.
Address Mercy Hosp. Date signed 9-29-46

G44102 BALTIMORE CITY HEALTH DEPARTMENT ✓ G44102

CERTIFICATE OF DEATH 937

Registered No.

Every item of information should be carefully supplied. Take correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 So Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 So Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rachel Yaffe

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Isaac
13. Birthplace Lith

MOTHER 14. Maiden Name Rosey
15. Birthplace Lith

16 (a) Informant Heyman Yaffe
(b) Address 107 So Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-46 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Druidheim Ave
Jacob Levin Ind

18 (a) Funeral director
(b) Address 1439 E. Baltimore St

19 (a) 2946 Recorded by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27-1946 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945 to Sept 27 1946. and that I last saw her alive on Sept 24 1946.

Immediate cause of death: Congestive heart failure — Duration: 1 month

Due to Generalized arterio-sclerosis — 20 years

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Cohen
Address 1804 Eutaw Place Date signed 9/27/46

VS 150

G44103 BALTIMORE CITY HEALTH DEPARTMENT ✓ G44103

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Aves.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2767 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE C. DeVED

3 (b) If veteran, name war W. W. I

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Kathryn U. DeVed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8- 1883

8. AGE: Years 63 Months 2 1 Days 19 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Pres. Geo. C. DeVed & Sons

11. Industry or business Sash Weight Co.

FATHER 12. Name George L. DeVed

13. Birthplace N. Y.

MOTHER 14. Maiden Name Louise Schmidt

15. Birthplace N. Y.

16 (a) Informant Mrs. Kathryn U. DeVed

(b) Address 2767 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-1946 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave

SEP 29 1946 (Date received) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1946, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1946, to 9/27 1946 and that I last saw h alive on 9/27 1946

Immediate cause of death FATTY DEGENERATION OF LIVER

Due to ACUTE GASTRITIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: FATTY LIVER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Rubinstein

Address 3706 Rondale Date signed 9/27/46 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

4104 BCH G 56020 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 157a 644104 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2723 Riggs Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 Riggs Ave (If no street location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wayne Leslie
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 9/46
8. AGE: Years Months Days 18 Hours 19 Under one day hr. min.
9. Birthplace Balto (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles R Leslie
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Fuller
15. Birthplace Balto

16 (a) Informant Chas R Leslie
(b) Address 2723 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St
(Date filed by Registrar) SEP 30 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1946, at 12 M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 17 1946 to Sept 28 1946 and that I last saw h[illegible] alive on Sept 28 1946

Immediate cause of death: Tuberculous Meningitis
Antecedent causes: Probably Staphylococcus
Due to: Spinal Bifida
Contributory causes: Leucocytosis
Other Conditions: Internal Hydrocephalus
(Include pregnancy within three months)
Date of operation none
Major findings of operation:
of autopsy: none

Duration: a day, a day, since birth

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? (Specify type of place)
(e) Means of injury
23. Signature Julius A Thalheimer
Address 1219 Eagle Date signed 9/28/46.

VS 150

X

G44105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 85

G44105
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 E. Ostend St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles B L Loyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1933

8. AGE: Years	Months	Days	If less than one day
13	3	15	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H. Loyd
13. Birthplace Chesapeake City Md.

MOTHER
14. Maiden Name Hilda Shelbin
15. Birthplace Indiana, Pa.

16 (a) Informant Mrs. Hilda Loyd
(b) Address 105 E. Ostend St.

17 (a) Burial (b) Date thereof 9/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) SEP 30 1946 (b) Registrar
(Date received by Local Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1946 at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Epilepsy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/28/46

Edmington Williams, M.D.

Contents may be confidentially imparted only to physicians and coroners; please write the causes of death clearly and legibly.

G44106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G44106 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2729 Hudson st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 Hudson st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Danowska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27/82

8. AGE: Years 64 | Months - | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Grunski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Stella Salkowska
(b) Address 2729 Hudson st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral [illegible] Trakowski
(b) Address 1000 S. Kenwood ave

19 (a) [illegible] (Registrar)

SEP 30 1946

Huntington Hill

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1946 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Sept 29 1946 and that I last saw h[illegible] alive on Sept 29 1946

Immediate cause of death	Duration
Diabetes Mellitus.	Aug 15/45
Arteriosclerotic CV-Disease.	
Due to Myocardial Failure	Sept 1/46
Due to [illegible]	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Johnson M. D.
Address 842 E. Eager Date signed 9-30-46

G44107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G44107
Registered No.

CHK-31893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8- 6- 4-
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 N. Robinson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7-1875

8. AGE: Years	Months	Days	If less than one day
71	3	20	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Duncan
13. Birthplace Penna.

MOTHER
14. Maiden Name Susan Fleming
15. Birthplace Penna.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd

18 (a) Funeral director John F Kleppe Inc
(b) Address 716 Light St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 19 46 at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 19 38 to Sept. 27 19 46 and that I last saw h alive on Sept. 27 19 46.

Immediate cause of death Septicemia — Duration 1 wk

Due to Generalized Arteriosclerosis —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund B Beacham
Address Balto City Hosp Date signed 9/30/46

VS 150

G44108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered No. G44108

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3818 Yolanda Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3818 Yolanda Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edwin Kirwan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or wife~~ Dora C. Kirwan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1861

8. AGE: Years 84 | Months 10 | Days 0 | If less than one day hr. min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Canned Goods Packer

FATHER
12. Name Samuel Kirwan
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Mary Ann Windsor
15. Birthplace Dorchester Co. Md.

16 (a) Informant Mrs Earl Herrmann
(b) Address 1019 Register Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 SEP 30 1946 (Date received by local reg.) (b) Huntington Williams, MD

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29th 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Sept 29 1946 and that I last saw him alive on 27 Sept 1946

Immediate cause of death: Carcinoma, Tongue — Duration 6 mo.
& metastasis To Liver

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry M. Zimmerman

Address 2851 Hartford Rd Date signed 9-30-46

Physician

G44109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G44109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 North Gilbert st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N Gilbert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henrietta Hearns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife James Hearns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1894

8. AGE: Years 52 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Mathews Cnty Va (Town, county and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Nat Adams

13. Birthplace Richmond Va

MOTHER 14. Maiden Name Ellen Clark

15. Birthplace Mathews Cnty Va

16 (a) Informant James Hearns

(b) Address 610 N. Gilbert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3, 1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Baltimore Cnty Md

18 (a) Funeral director Joseph A. Sisly

(b) Address 660 W Baltimore Street

19 (a) Sept 30 1946 (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1946 at 7.15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 27 1946 to Sept 28 1946 and that I last saw h[illegible] alive on Sept 28 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 754 Broadway Date signed 9/30

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D — Registered No. G44110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution:
Cold Spring Home for Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2271 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josie B. Spafford

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-9720

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
74?	?	?	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Welfare

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Mondshour
(b) Address 2271 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

SEP 30 1946 (Date received by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 28 1946 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 23 1946 to SEPT 28 1946 and that I last saw her alive on SEPT 27 1946

Immediate cause of death	Duration
BRONCHOPNEUMONIA	2 days
Due to CEREBRAL HEMORRHAGE	16 wks.
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	? -

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Kleiman, M.D.
Address 3803 EDMONDSON AVE Date signed 9/28/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G44111 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town ~~1213 Northwood Rd~~ (Northwood)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 South Wind Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Louvie Effie Nunn. EFFIE LOUISE NUNN

3 (b) If veteran, name war No

3 (c) Social Security Account No. None.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife J. Edward Nunn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1876

8. AGE: Years	Months	Days	If less than one day hr.	min.
70 yrs	6	17		

9. Birthplace ~~Baltimore~~ Emmittsburg Md. (Town, county, and state)

10. Usual Occupation Home Maker.

11. Industry or business Home Maker.

FATHER
12. Name Jerry Wilkes.
13. Birthplace Baltimore Maryland.

MOTHER
14. Maiden Name Laura Shook.
15. Birthplace Maryland.

16 (a) Informant Mrs Mary Summers
(b) Address 1213 South Wind Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery ~~XXXXXXX~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. Md.

19 (Signature of registrar) SEP 30 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28, 1946, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1946 to Sept 28 1946, and that I last saw h[illegible] alive on Sept 27 1946.

Immediate cause of death	Duration
Cardiac insufficiency.	6 mo.
Due to Aortic stenosis	10 yrs.
Due to	
Other Conditions Bronchitis	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: ~~Autopsy~~ Aortic stenosis; left ventricular hypertrophy

of autopsy: Bronchitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Bachrach M. D.
Address Church Home Hospital Date signed Sept 29, 46

VS 150

G44112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G44112

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Fork
(If outside city or town limits, write RURAL and give town)
(d) Street No. Stoney Batter Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth M. Strohmeyer

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	none	F	W	Married

6 (b) Name of husband or wife William C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1892

8. AGE: Years	Months	Days	If less than one day
54	4	20	hr. min.

9. Birthplace Md (Balto.) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Strøter
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Ringsdorf
15. Birthplace Balto., Md.

16 (a) Informant Mr. Wm. C. Strohmeyer
(b) Address Stoney Batter Rd. Fork, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 30 1946 Huntington Nolliston, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1946, at 3 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1946 to Sept 29 1946 and that I last saw her alive on Sept 29 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension and cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation
of autopsy autopsy performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ethel J. Tuckner
Address St Agnes Hospital Date signed 9/30/46 M. D.

X

G44113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G44113 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Montebello Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Montebello Terr. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY P. CANOLES

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James H. Canoles
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Mar. 14, 1872
8. AGE: Years 74 Months 6 Days 16 If less than one day hr. min.
9. Birthplace Balto. Co. (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name George W. Young
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name Mary Holland
15. Birthplace England

16 (a) Informant Mr. James H. Canoles
(b) Address 2900 Montebello Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery or crematory
Location Monkton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 30 1946 (Date rec'd by registrar) Hunting Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1946 at 6:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 27 1946 and that I last saw alive on 19

Immediate cause of death Coronary Thrombosis Duration

Due to Myocarditis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ira E. Whitehurst, M.D.
Address 30 E Mnt Royal Ave Date signed 9/28/46

VS 190

24114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24114 Registered No.

Every item of information should be carefully supplied. Ages, names of parents, etc., if unknown, write UNKNOWN. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3307 Gwynns Falls Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Nunsen Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7079

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edythe Margaret Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	6	hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation Auditor
11. Industry or business Stieff Silver

FATHER
12. Name John Henry Thomas
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Emma E. Deininger
15. Birthplace Pa.

16 (a) Informant Mrs. Edythe M. Thomas
(b) Address 3307 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director
(b) Address 4510 Liberty Heights Ave.

SEP 30 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1940, to Sept 27 1946 and that I last saw h[illegible] alive on Sept 26 1946.

Immediate cause of death [illegible]

Due to [illegible]

Due to

Other Conditions [illegible]
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 4509 Liberty Hgts Ave Date signed

VS 150

G44115 BALTIMORE CITY HEALTH DEPARTMENT G44115

CERTIFICATE OF DEATH 134a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 N. East Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin T. Benton

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7816

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Anna E. Welzel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1893

8. AGE: Years 53 Months 1 Days 13 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Conn. Can Co.

FATHER
12. Name William Benton
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Jubb
15. Birthplace Baltimore

16 (a) Informant Anna E. Benton
(b) Address 420 N. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1946, at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1946 to Sept. 26 1946; and that I last saw him alive on Sept. 26 1946

Immediate cause of death: Coronary thrombosis — Duration 20 min.
Due to Coronary heart disease 1 mo.
Due to
Other Conditions Renal Calculus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ward Stemples, M.D.
Address 5007 E. Fayette Date signed 9/30/46

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G44116

Registered No. 2611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3303 Clyde St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Clyde St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Truitt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Jeanetta M. Schattner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1902

8. AGE: Years	Months	Days	If less than one day
44	1	8	hr. min.

9. Birthplace Salisbury Md.
(Town, county, and state)
10. Usual Occupation Dry Cleaner
11. Industry or business Owner

FATHER
12. Name W. P. Truitt
13. Birthplace Saulsbury Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Jeanetta M. Truitt
(b) Address 3303 Clyde St.

17 (a) Burial (b) Date thereof 10/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Oaklawn

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1539 Broadway

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 100 SEP 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1946 to Sept 26 1946
and that I last saw him alive on Sept 26 1946 11:30 P.M.

Immediate cause of death Pneumonia Left base & Pleurisy
Due to Grippe cold

Duration
18 days
1 wk

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Craft M.D.
Address 5010 Granite Rd Date signed 9/28/46

correct age is especially important. Physicians: please write the

Postal Cashier G44117 9-48545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 64

G44117 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 163 W Henrietta St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	3		hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Jones
13. Birthplace Md

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Md

16 (a) Informant Mary Johnson
(b) Address 163 W Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A.Co. Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1044 Montgomery St

19 (a) SEP 30 1946 (b) Registrar Washington Hollingsworth, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1946, at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Status Thymico - lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer L Hearn M.D.
Medical Examiner.
Date signed 9-26-46

G44118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G44118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 W. Hamwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Nicholson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Etta M. Nicholson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-30-1916

8. AGE: Years: 30 | Months: 8 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Work

11. Industry or business:

FATHER
12. Name: Lawrence Nicholson
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Susie Gross
15. Birthplace: A. A. Co., Md.

16 (a) Informant: Jennie Johnson
(b) Address: 1106 Russell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 30, 1946 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem.
Location: Brooklyn, Md.

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Hanover ave

SEP 30 1946 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1946, at 4:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Intracranial Hemorrhage
Due to Bullet wound.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-26-46 at 11:55 P. M.
(b) Where did injury occur? Wrecker St. & Fremont Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm

23. Signature [illegible] M.D. Medical Examiner.
Date signed 9-27-46

VS 15t

G44119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G44119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosie Baker Lawrence

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Charles Lawrence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Virginia Carter
(b) Address 918 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 100 Bentley ave
(c) Huntingtown Williams, Md. (Date received by registrar) Registrar

SEP 30 1946

VS 280

MEDICAL CERTIFICATION

9/26/46

20. DATE OF DEATH 9/26 46 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 46 to 9/26 46 and that I last saw h[illegible] alive on 9/26 46

Immediate cause of death — Duration

Coronary Occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Burkett M.D.
Address [illegible] Date signed 9/26/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. T[illegible]

Please print or type. Fill out completely. Be sure to give cause of death clearly and legibly.

4120 BALTIMORE CITY HEALTH DEPARTMENT X ✓ Reg. No. 044120
CERTIFICATE OF DEATH 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8126 Cornwall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert A. Warden Jr. WARDEN

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1925

8. AGE: Years 20 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Steubenville, Ohio (Town, county, and state)
10. Usual Occupation student
11. Industry or business

FATHER
12. Name Robert A. Warden
13. Birthplace New York.

MOTHER
14. Maiden Name
15. Birthplace Ohio

16 (a) Informant Robert A. Warden
(b) Address 8126 Cornwall Rd. Balto. 22, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Taylor Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) SEP 30 1946 (Date rec'd by registrar) (b) Huntingtown, Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1946 at 4:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection, or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial hemorrhage, Laceration
Due to Of brain

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/22/46 at 12-23 A. M.
(b) Where did injury occur Willow Spring Rd. & Dundalk Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision of two autos.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 9-28-46

VS 151

G44121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G44121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 N. Linwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 N. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE ALEXANDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	-----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William H. Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1880

8. AGE: Years	Months	Days	If less than one day
66	6	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business House- Work.

FATHER
12. Name Henry Becraft
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Betty Watson
15. Birthplace Balto., Md.

16 (a) Informant Dora Reardon (Sister)
(b) Address 418 N. Linwood Ave.

17 (a) Burial (b) Date thereof 10-1-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location E. North Ave.

18 (a) Funeral director Charles L. Zeiler.
(b) Address 3605 Fait Ave.

SEP 30 1946 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION 10:30

20. DATE OF DEATH Sept. 28 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 15 1946, to Sept. 28 1946, and that I last saw h.er alive on Sept. 28, 1946.

Immediate cause of death	Duration
CARDIAC THROMBOSIS	1 HOUR
Due to HYPERTENSION	10 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. J. B. Newton M.D.
M. D.
Address 448 N. Luzerne Ave. Date signed 9-29-46

VS 180

correct age is especially important. Physicians: please write the

G44122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44122

Registered No. 47a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Hyde
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sunshine ave & Battons Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Martin E Spangler
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Elizabeth
6 (c) If given, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 7- (1886)

8. AGE: Years 55 (59) | Months 9 | Days 22 | If less than one day: hr. 18 9 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Ambrose Spangler
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Martin E. Spangler
(b) Address Sunshine & Battons Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-46 (month) (day) (year)
(c) Cemetery or crematory Morelands
Location Baltimore

18 (a) Funeral director Leonard D. Ruth
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Huntington & Williams M.D.

SEP 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1946 to Sept 29 1946 and that I last saw h[illegible] alive on Sept 24 1946

Immediate cause of death — Duration
Ca Cancroma of Larynx
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ca of Larynx

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H Young M.D.
St Joseph Hosp. Date signed 9/29/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr G44123

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G44123
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 Woodhome Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Woodhome Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ellen Gerben

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1864

8. AGE: Years	Months	Days	If less than one day
81	10	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Gerben
13. Birthplace Germany

MOTHER
14. Maiden Name Bridget Hughes
15. Birthplace Ireland

16 (a) Informant Mrs. Louis M. Kell
(b) Address 3100 Woodhome Avenue-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's, Govans
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) SEP 30 1946 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29, 1946, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to Sept 29 1946 and that I last saw h. alive on Sept 29 1946

Immediate cause of death: Coronary thrombosis — Duration 1 hr.

Due to: Generalized arteriosclerosis — Duration 5 yrs?

Due to: Goitre, colloid — Duration life

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed 9/30/46
M. D.

Huntington Mitchell M.D.

B44124. BALTIMORE CITY HEALTH DEPARTMENT B44124
Registered No.
CERTIFICATE OF DEATH 1240

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Fleet St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred Kozak or KOZAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER
12. Name Philip Kozak
13. Birthplace Russia
14. Maiden Name Cecelija Luke
15. Birthplace Russia

16 (a) Informant George Kozat
(b) Address ? Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1 - 46 (month) (day) (year),
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run Rd & Co

18 (a) Funeral director John J Gallagher Jr
(b) Address 423 S. Paca St.

19 (a) Filed SEP 30 1946 (b) Registrar Washington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1946, at 12. PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17th 1946. to Sept 28 1946, and that I last saw him alive on Sept 28 1946.

Immediate cause of death
Hemorrage
Esophageal Varicis 1
Due to Rupture of Oesophageal Varicose
Due to
Other Conditions Cirrhosis of the Liver
(Include pregnancy within 3 months of death)

Duration
Sept 26 to Sept 29.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Franklin Sq. Hosp Date signed 9/29/46

VS 150

G44125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G44125
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution: Digest Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET CAPLAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Uriel
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-46 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Baltimore Md

18 (a) Funeral director Jack Lewis Inc
(b) Address 1600 E. Baltimore St

19 (a) SEP 30 1946 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1946, to 9-30 1946, and that I last saw h alive on 9-30 1946.

Immediate cause of death: Hypertensive Cardiovas disease
Duration:

Due to: Diabetes Mellitus

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin
Address Levindale Date signed 9/30/46

Physician: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

G44126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G44126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 E. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Young

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-8246

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara E (Pattison)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27 1868

8. AGE: Years 78 Months 1 Days 1 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Black & Decker

FATHER
12. Name Sylvester Young
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name [illegible] ?
15. Birthplace Baltimore

16 (a) Informant William M Young (Son)
(b) Address 3717 Hillsdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 / 1 /46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave Baltimore Md

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave

SEP 30 1946 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1946, at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11, 1946 to Sept. 28, 1946 and that I last saw h im alive on Sept. 28, 1946

Immediate cause of death: Cardio - respiratory failure — Duration

Due to: Carcinoma of sigmoid colon

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation Sept. 24, 1946
Major findings of operation: Carcinoma of sigmoid colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B Hall M.D.
Address [illegible] Date signed 9-28-46

VS 150

X

correct age is especially important. Physicians: please write the

G44127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G44127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 N. Pearl Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Pearl Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no.

3 (a) FULL NAME Joseph John Massey.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-2911

4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Richmond, Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Balto. Chemical Co.

FATHER
12. Name Louis Massey
13. Birthplace Virginia

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Virginia

16 (a) Informant Annie Massey
(b) Address 412 N. Pearl Street

17 (a) Burial (b) Date thereof 10/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Mt. Calvary Location [redacted] Md.

18 (a) Funeral director Geo. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) Registrar

SEP 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1946 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1, 1946 to Sept 27 1946 and that I last saw him alive on Sept 27 1946.

Immediate cause of death Uremic Complications — Duration Grad 30 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Stewart M. D.
Address 692 W Franklin St Date signed Sept 27, 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44128 BG 49772 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 119a G44128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) SAME

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Appleton ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN WARGO

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-46

8. AGE: Years	Months	Days	If less than one day
—	3	23	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Joseph P. Wargo
13. Birthplace Penna.

MOTHER
14. Maiden Name Agnes M. Stonis
15. Birthplace Penna.

16 (a) Informant Mr. Joseph Wargo
(b) Address 318 S. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 1 (day) 46 (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd
18 (a) Funeral director John Edward Sons
(b) Address 90-92 Collins St.
19 (a) Filed 30 (b) 1946 (Date filed by registrar)
Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1946, at 4:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1946, to 9-29 1946, and that I last saw her alive on 9-29 1946.

Immediate cause of death Circulatory Collapse — Duration

Due to BACTEREMIA, STREPTOCOCCUS with Presumptive Pneumococcic

Due to ACUTE BILATERAL OTITIS MEDIA

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address University Hosp. Date signed 9-29-46 M. D.

VS 150

X

G44129

TH. 99915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

G44129

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6- 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Ay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1st. 1886

8. AGE: Years	Months	Days	If less than one day
60	6	26	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name (Gus Ay) Gustav ay
13. Birthplace Germany

MOTHER 14. Maiden Name Augusta ~~Smith~~ Schmidt
15. Birthplace Germany

16 (a) Informant: Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 9/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Av.

19 (a) SEP 30 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27th 1946, at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1946 to Sept 27 1946 and that I last saw him alive on Sept. 27 1946

Immediate cause of death: Pulmonary tuberculosis, far advanced — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marcy E. McWilliams M. D.

Address Balto. City Hosp. Date signed 9/27/46

X

Write the causes of death clearly and legibly. Physicians: please write the age is especially important.

G44130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (92)

G44130 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE MEHR

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Harry Mehr
(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Aug. 28. 1851

8. AGE: Years	Months	Days	If less than one day
95 97	11	0	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ferdinand W. Ulrich
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Bower
15. Birthplace Germany

16 (a) Informant Mrs.O.H.Duker (Daughter)
(b) Address 928 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.30.19 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore, Md.

19 (a) 30 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28. 1946 at 8.00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Sept 28 1946 and that I last saw HER alive on Sept 27 1946.

Immediate cause of death: Dilated Heart with thrombosis — Duration 2 hrs

Due to Chronic Endocarditis

Due to Chronic Myocarditis 5 Yrs

Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature O. H. Duker M. D.
Address 928 E. North Ave Date signed 9/29/46

VS 150

G44137 Over

BALTIMORE CITY HEALTH DEPARTMENT X G44131
CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town Harwoods (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beverly Downs
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female | 5. Color or race black | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/46

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Downs
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Claggett
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/46 (month) (day) (year)
(c) Cemetery or crematory Chews
Location West Rock, Md.

18 (a) Funeral director T. A. HARDESTY & SON
(b) Address Fidelesville, Md.

19 (a) 30 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 15"

20. DATE OF DEATH Sept 29 1946 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1946 to 9-29-1946 and that I last saw h[illegible] alive on 9-29-1946.

Immediate cause of death: Intracranial Hemorrhage — Duration 2 Days
Due to: Prolonged and difficult labor
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dorothea G. Jaggis M. D.
Address Johns Hopkins Hospital Date signed 9/30/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44132 B.C.H. 59202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G44132 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby George Marjorie Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-46

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Geo. Scott

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Marjorie Dorsey

15. Birthplace Balto. Md

16 (a) Informant Marjorie Scott

(b) Address 1111 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2 46 (month) (day) (year)

(c) Cemetery or crematory Cookesville

Location Montgomery Co Md

18 (a) Funeral director Robert L. Snowden

(b) Address Rockville Md

19 (a) 9-30-1946 (Date received by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29-1946, at 9 ~~P~~ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18-1946, to 9-29-1946 and that I last saw him alive on 9-29-1946.

Immediate cause of death	Duration
Premature Infant	
Due to Unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Asplin M.D.

Address 416 N. Eden St. Date signed 9/30/46

G44133 G44133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √24a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE STS.
(c) Hospital or institution:
UNIVERSITY HOSPITAL 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 MYRTLE AVE (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD WILLIAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-43

8. AGE: Years	Months	Days	If less than one day
2	10	—	hr. min.

9. Birthplace DARLINGTON, S. C.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name James Williams
13. Birthplace Darlington, S.C.

MOTHER
14. Maiden Name Juanita Nash
15. Birthplace Charlotte, S.C.

16 (a) Informant Mrs. Juanita Williams
(b) Address 223 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrose
Location

18 (a) Funeral director Mrs Katie R. Williams
Address 322 E. Schroeder St.

19 (a) P 30 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1946, at 7:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1946, to 9-28 1946, and that I last saw him alive on 9-28 1946.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Univ. Hosp. Date signed 9-28-46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ff
(e) Length of stay in Baltimore (yrs., mos., or days) Carroll

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 173 N. Schroeder
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie A Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 65 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Bella Haven, Nord Hampton County, Va.
(State, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Robert Carroll
13. Birthplace Bell Haven, Va.

MOTHER 14. Maiden Name Margaret Smith
15. Birthplace Bell Haven, Va.

16 (a) Informant Mary White
(b) Address 948 Bennett Place

17 (a) Burial (b) Date thereof Sept. 20, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Rafus Williams
(b) Address 322 N. Schroeder St.
Huntington Williams, M.D.

SEP 20 1946 (Date rec'd by Registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/46 19__, at 10:50 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Revans M.D.
Medical Examiner.
Date signed 9/26/46

G44135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G44135 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 W. Lanvale Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Tarr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louis A. Tarr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business - --------

FATHER
12. Name Bernard Roden
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Revell
15. Birthplace Ireland

16 (a) Informant Miss Margaret L. Roden
(b) Address 2420 W. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meamber
(b) Address 805 N. Calvert St.

19 (a) SEP 30 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6, 1945 to Sept. 28, 1946 and that I last saw her alive on Sept. 27, 1946

Immediate cause of death	Duration
Cardiac Failure	3 mon.
Due to Arteriosclerotic Cardio-vascular Renal Disease	18 mon.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. A. Kemp

Address 3030 Edmondson Avenue Date signed M. D. 9/28/46

VS 150

Physicians: Every item of information should be carefully supplied. The correct age is especially important. Please write the causes of death clearly and legibly.

G44136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G44136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 1514 Braddish Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Braddish Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Walter Dews

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife La Verna Dews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1917

8. AGE: Years	Months	Days	If less than one day
29	2	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Chief Boatswain (U.S. Navy)
11. Industry or business U.S.S. Yancey

FATHER
12. Name George D. Dews
13. Birthplace Georgia

MOTHER
14. Maiden Name Nana Belle Cooksey
15. Birthplace Georgia

16 (a) Informant Mrs. La Verna Dews
(b) Address 1504 Braddish Ave

17 (a) Burial (b) Date thereof Oct 2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Frederick Rd

18 (a) Funeral director William Cook Inc
(b) Address 147 St Paul St

19 (a) SEP 30 1946 (b)
(Date received by Registrar) Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1946 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating gas
Due to
Other Conditions Disposedancy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/28/46 about 1:00 A.M.
(b) Where did injury occur? 1514 Braddish Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury inhaled gas vapors from open gas stove

23. Signature C. F. Sullivan M.D.
Medical Examiner.
Date signed 9/28/46

G44137
50065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178

G44137
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giacomo [illegible] Chiapparelli
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-10-0768

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-6-93
8. AGE: Years 53 5/12 Months 10 11 Days 18 22 If less than one day hr. min.
9. Birthplace Italy (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Chiapparelli
13. Birthplace Italy

MOTHER
14. Maiden Name Francesca David
15. Birthplace Italy

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1st 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 (a) (Date rec'd by registrar) (b) Huntingtow Williamsport Md.

OCT 30 1946

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Sept. 28 1946 at 3:05 M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1946 to Sept. 28 1946 and that I last saw him alive on Sept. 25 1946.
Immediate cause of death Shock

	Duration
Due to Peritonitis	4 D
Due to Perforated duodenal ulcer post-op	
Other Conditions Hypertension, jaundice	

(Include pregnancy within 3 months of death)
Date of operation 9/24/46
Major findings of operation Bleeding ulcer. Later strong patient
of autopsy Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry G. Bahmon
Address J. H. Hospital Date signed 9/30/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

G44138

Registered No.

The space for information should be carefully supplied. Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Chelsea Terrace #16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Zies

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barbara R. Zies

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1867

8. AGE: Years	Months	Days	If less than one day
78	9	21	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: President

11. Industry or business: Charles Zies & Sons Co.

FATHER
12. Name: Charles W. Zies
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mr. Theodore C. Zies
(b) Address: 810 Woodington Rd. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (b) Woodington Rd. Williamsburg
(Date received by local registrar) (Registrar)

SEP 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29, 1946, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27, 1946 to Sept 27, 1946; and that I last saw him alive on Sept 24, 1946.

Immediate cause of death: Cardiac failure — Duration

Due to Enteritis chronic — Diabetes & Gangrene of right foot

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Manuel Agnew M. D.

Address: Md. General Hosp. Date signed: 9/29/46

X

G44139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V111c

Registered No. G44139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hosp. 8 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 E. University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME India W. Hill

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife: Gerald W. Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1899

8. AGE: Years	Months	Days	If less than one day
47	0	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Chester F. Fussell
13. Birthplace Pa.

MOTHER
14. Maiden Name Grace Nagle
15. Birthplace Md. (Balto.)

16 (a) Informant Gerald W. Hill
(b) Address 212 E. University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1946 at 7:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1946 to 9-29 1946, and that I last saw her alive on 9-29-1946.

Immediate cause of death	Duration
Pulmonary & cerebral edema	
Due to Malignant essential hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gary T. Griggs M. D.
Address Univ. Hosp. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218 G44140

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 S. Collington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA M. MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband ~~WIDOW~~ J. Fred Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1859

8. AGE: Years	Months	Days	If less than one day
87	1	7 17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Jacob H. Buler
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta C. Oehue
15. Birthplace Germany

16 (a) Informant Mrs. Beulah M. Hill
(b) Address 116 S. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery ~~WOODLAWN~~ Woodlawn
Location Woodlawn Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1946 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to 9/27 1946 and that I last saw h[illegible] alive on 9/27/46 1946

Immediate cause of death	Duration
(a) Senility	1 mo
Due to (b) Chronic Nephritis	2 mo
Due to,	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George D. [illegible] M. D.
Address 4375 Pattonsville Rd. Date signed 9/30/46

VS 150

G44141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G44141 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Gwynns Falls Pkwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Gwynns Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA V. FRAZEE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	no	Female	White	Widow

6 (b) Name of husband or wife George B. Frazee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1860

8. AGE: Years	Months	Days	If less than one day
85	10	9	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Wright
13. Birthplace Md

MOTHER
14. Maiden Name Eliza. Jones
15. Birthplace England

16 (a) Informant Carrie L. Frazee
(b) Address 3305 Gwynns Falls Pkwy.

17 (a) Burial (b) Date thereof 10/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 30 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1946 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 28 1946 and that I last saw him alive on Sept 7 1946.

Immediate cause of death Cardiac failure — Duration

Due to myocardial insufficiency & Coronary occlusion

Due to Arteriosclerotic Cardio & vascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature L. Shorofsky M.D.
M. D.
Address 601 N. Monroe St Date signed 9/30/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44142 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1665 Bakebury Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Celeste Garrison (Fletcher)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1903

8. AGE: Years 43 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Fletcher

13. Birthplace Va

MOTHER 14. Maiden Name Katie Bowie

15. Birthplace Brid Md.

16 (a) Informant Walter Garrison

(b) Address 1665 Bakebury Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3/46 (month) (day) (year)

(c) Cemetery or crematory Arbutus M. Park

Location Arbutus Md.

(a) Funeral director Mrs. Ruth A. Elliott & Dept

Address 1169 N. Caroline St.

SEP 30 (b) 1946 Livingston Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/46 at 1:50 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Lauro M.D. Medical Examiner.

Date signed 9/30/46

G44143 | BALTIMORE CITY HEALTH DEPARTMENT | G44143

CERTIFICATE OF DEATH 1634

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2908 Echodale Avenue

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Echodale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta ~~Ulrich~~ Ulrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Carl Ulrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1893

8. AGE: Years	Months	Days	If less than one day
53	7 8	29	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation house wife

11. Industry or business

FATHER
12. Name Henry Hemler
13. Birthplace Md

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Md

16 (a) Informant Carl P Ulrich
(b) Address 5314 Seamore Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1 46 (month) (day) (year)
(c) Cemetery or crematory National Cem
Location Balto Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) SEP 30 1946 (Date received by registrar) (b) Registrar Huntington Williams

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27-1946, at 11 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-27- at A.M.
(b) Where did injury occur? 2908 Echodale Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illum gas jet to kitchen range

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 9-27-46

G44144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/186a

Registered No. G44144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 85 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 ECHODALE AVE. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME WILLIAM T. HALLER

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife MRS. NAOMI HALLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 18, (1866) 1868

8. AGE: Years	Months	Days	If less than one day
78 (80)	8	10	hr. min.

9. Birthplace MARYLAND. (Town, county, and state)
10. Usual Occupation RETIRED.
11. Industry or business

FATHER
12. Name JACOB HALLER
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name MARY BAER.
15. Birthplace MARYLAND.

16 (a) Informant MRS. NAOMI HALLER
(b) Address 2913 ECHODALE AVE 14

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location FREDERICK MD

18 (a) Funeral director Ulloyd Funeral Home
(b) Address 2400 Orleans St.

19 (a) SEP 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 28 1946 at 12:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 5 1946 to SEPT 28 1946 and that I last saw him alive on SEPT. 28 1946.

Immediate cause of death EXHAUSTION — Duration
Due to GANGRENE EXTREMITY
Due to FRACTURE FEMUR.
Other Conditions BED SORE
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 41
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-5-46 at 12:30 P.M.
(c) Where did injury occur? Calvert at Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Fell to ground for some unknown

23. Signature James A. Roberts M.D.
Address Mercy Hospital Date signed 9-28-46

VS 150

* Howard J. Meadows M.D.

- Deceased did not know what caused him to fall — did not slip — nor was he struck. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1186a

G44145 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Spotten
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-8-92
8. AGE: Years 53 Months 10 Days 20 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Hornberger
13. Birthplace Germany

MOTHER
14. Maiden Name Dena Janson
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 1946 (month) (day) (year)
(c) Cemetery or crematory Mackeal Memorial Park
Location Joppa Rd.
18 (a) Funeral director J. L. Miller
(b) Address 23 N Jefferson St.
19 (a) (Date rec'd by registrar) (b) Registrar

SEP 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1946 at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1946 to Sept 28 1946 and that I last saw her alive on Sept 28 1946.

Immediate cause of death: Respiratory failure — Duration 6 days
Due to: Tetanus
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Sept 27, 1946
Major findings of operation: Infected wound scalp. E. Tremus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Sept 27, 1946 at 3.00 A M
(c) Where did injury occur? Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell down cellar steps
23. Signature Henry C. Porter
Address Johns Hopkins Hosp Date signed 9/29/46 M.D.

VS 150

Howard J. Moseley, M.D.

G44146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √122a

G44146 Registered No.

Correct age if impossible to secure. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2330 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr John J. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29-1898

8. AGE: Years	Months	Days	If less than one day: hr. min.
47		1	

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business

FATHER
12. Name Thomas H. White
13. Birthplace Austria

MOTHER
14. Maiden Name Margaret Kress
15. Birthplace Balto. Md.

16 (a) Informant George H. White
(b) Address 2441 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3/46 (month) (day) (year)
(c) Cemetery or crematory Bel Air Memorial Park
Location Eastern Ave.

18 (a) Funeral director Jos. A. Miller
(b) Address 2334 Jefferson St.

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1946 to Sept 29 1946 and that I last saw him alive on Sept 29 1946

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Strangulated umbilical Hernia	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation Sept 28, 1946

Major findings of operation Strangulated umbilical Hernia

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Young M.D.

Address 21 S. Joseph Ave Date signed 9/29/46

Huntington Williams, M.D.

X

G44147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No. G44147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL 51

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2514 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Becker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-1875

8. AGE: Years	Months	Days	If less than one day
71	7	3	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Packing House Laborer
11. Industry or business

FATHER
12. Name Amos Becker
13. Birthplace South Carolina

MOTHER
14. Maiden Name Nancy McFoulds
15. Birthplace South Carolina

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1. 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore city

18 (a) Funeral director Bothe Group
(b) Address 1402 Ashland ave

19 (a) SEP 30 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1946, at 7 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1946, to 9-21 1946 and that I last saw h[illegible] alive on 9-21 1946.

	Duration
Immediate cause Uremia	2 hrs.
Due to Chronic Glomerulo-nephritis	1 yrs.
Due to Benign Prostatic Hypertrophy	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas H. Laird M.D.
Address Johns Hopkins Hosp signed 20 Sept 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44148
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
Pineridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) to yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Aiken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA S. GATTO

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Domenico Gatto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1871

8. AGE: Years	Months	Days	If less than one day
75	4	7	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stephen
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Domenico Gatto
(b) Address 2217 Aiken St.

17 (a) Burial (b) Date thereof 10/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 29 1946 (b) W. Thomas Registrar
(Date) (By Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1946 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 2√, to Sep 28 1946, and that I last saw her alive on Sept 24 1946

Immediate cause of death	Duration
Myocardian Degeneration	√ Years
Due to Hypertension,	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. W. Hoffmann M. D.
Address 8 East Read St Date signed 9/30/46
M. D.

X

G44149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 51B

G44149
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES OWINGS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1861

8. AGE: Years	Months	Days	If less than one day
85	7	12	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation United Railway (retired)
11. Industry or business

FATHER
12. Name Henry Addison Owings
13. Birthplace Md.

MOTHER
14. Maiden Name Miranda M. Ritter
15. Birthplace Md.

16 (a) Informant Mrs. Mabel I. Schiutker
(b) Address 2913 Christopher Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) SEP 30 1946 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1946 at 10 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to 9/27 1946 and that I last saw h[illegible] alive on 9/27 1946

Immediate cause of death — Duration
Bronchio pneumonia — 5 days
Benign Prostatic hypertrophy — 3 yrs?
Due to Carcinoma Prostate ? —
Pyelotage Calculi —
Bilateral Pyonephrosis — 6 mos
Staph infection Urinary tract — 1 yr
Other Conditions Generalized Arteriosclerosis — 10 yrs
Renal Insufficiency

(Include pregnancy within 3 months of death)
Date of operation 9/19/46
Major findings of operation: see above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. Kurt Hagaman M. D.
Address 212 N. Patterson Ave Date signed 9/30/46

VS 150

G44150 | MARYLAND STATE DEPARTMENT OF HEALTH | G44150

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 83a

Reg. Dist. No. ____

PLACE OF DEATH:

City or town: Hamilton Balto Md (If outside city or town limits, write RURAL and give nearest town)

Length in above place of death? ____

Hospital, institution, or street address where death occurred: Convalescent Home 470 Hampton Rd

Length in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto

City or town Middle River (If outside city or town limits, write RURAL and give nearest town)

Street No. Carroll Island Rd R.F.D. 14 (If rural, give LOCATION)

2.(a) If veteran, name war ____

1. (a) FULL NAME Wm Edward Brinkman

3. (b) Social Security Number 218-14-4884

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

(b) Name of husband or wife Florence M Brinkman

6.(c) If alive, give age ____ years

Birth date of deceased (mo., day, yr.) 4-18-82

AGE: Years 64 | Months 5 | Days 10 | If less than one day: hrs ____ min. ____

Birthplace Balto Co. Md. (Town, county, and state)

Usual occupation Truck farmer

Industry or business ____

12. Name Henry Brinkmann

13. Birthplace Balto Co Md.

14. Maiden name Mary Dryer

15. Birthplace Germany.

Informant Mrs. Wm E Brinkmann

Address Carroll Island Rd.

Burial, cremation, or removal. Which? Burial Date thereof 10-1-46 (month) (day) (year)

Cemetery or crematory Ebenezer Meth. Balto Co

Location ____

Funeral director Loudahn Funeral Home

Address 7401 Belair Rd

SEP. 30 1946 (Date rec'd by registrar) Hilliard Williamson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1946, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 22 1946, to Sept 28 1946

and that I last saw him alive on Sept 28 1946

Immediate cause of death: Cerebral Hemorrhage — DURATION 6 days

Due to Cerebral Arteriosclerosis

Due to ____

Other conditions Gen'l arteriosclerosis.

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE A L Kolodny M.D.

Address Redgate Rd Baltimore M.D. or other

Date signed Sept 29, 1946

G44151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

Registered No. G44151

please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Bal
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2786 Tivoly Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gazella Weinreich

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Maurice H Weinreich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/89

8. AGE: Years	Months	Days	If less than one day
57	6	23	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Robt D Long
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine Wolf
15. Birthplace W. Va

16 (a) Informant Mr M H Weinreich
(b) Address 2786 Tivoly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Loughran Funeral Home
(b) Address 7401 Belair Rd

19 (a) (Date rec'd by registrar) (b) Registrar SEP 30 1946 Washington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1946, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1946, to 9-29 1946, and that I last saw her alive on 9-29 1946.

Immediate cause of death Cardiac failure — Duration

Due to myocardial infarction

Due to coronary sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8-20-46
Major findings of operation: Multiple abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Hanby
Address Univ Hospital Date signed 9-29-46

G44152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1469

G44152 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4324 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4324 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SGT. HERBERT E. ROBINSON
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Anna Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5,1881

8. AGE: Years 65 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Talbot Co., Md. (Town, county, and state)
10. Usual Occupation Sgt. Balto. City P. Dept.
11. Industry or business

FATHER
12. Name Charles Robinson
13. Birthplace Talbot County, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Talbot County, Md.

16 (a) Informant Mrs. Herbert E. Robinson
(b) Address 4324 Parkside Drive

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lonsdale Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Interring for Baltimore, Md.

SEP 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28th, 1946 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Sept 28 1946 and that I last saw him alive on Sept 25 1946.

Immediate cause of death - Edgewonde of Pancreas
C Metastasis

Due to

Due to

Other Conditions Hypostatic Congestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: under one day

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Dooley, M.D.
Address 8 W Mt Vernon Pl Date signed Sept 30 1946

VS 100

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 S. Charles St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Hendricks

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/96

8. AGE: Years 50 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Register of Wills Balto. Md.

MOTHER FATHER

12. Name Miles C. Hendricks

13. Birthplace Baltimore, Md.

14. Maiden Name Grace C. Jones

15. Birthplace Baltimore, Md.

16 (a) Informant Miles C. Hendricks

(b) Address 3839 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-30/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location A.A. Co.

18 (a) Funeral director J.A. Krauss & Son

(b) Address 1216 S. Charles St.

19 (a) SEP 30 1946 (Local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1946, 12:40 a. M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/24 1945 to 7/27 1946 and that I last saw him alive on 9/25 1946.

	Duration
Immediate cause of death: Coronary Thrombosis	Immediate
Due to	
Due to	
Other Conditions: Hypertensive Cardio vas. Arterio Disease	14 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weiss

Address 226 Hanover St Date signed 9/30/46

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Use additional sheet if necessary. (Do not write above this line)

VS 190

G44154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy "A" Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-46

8. AGE: Years | Months | Days: 3 days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Miller
13. Birthplace ? Md

MOTHER 14. Maiden Name Violet Butler
15. Birthplace ? Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-46 (month) (day) (year)
(c) Cemetery or crematory Bethel Church of God
Location Winfield, Carroll Co. Md

18 (a) Funeral director C. M. Walsh
(b) Address Winfield Md

19 (a) OCT 1 - 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1946, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16-46 1946 to Sept 30 1946, and that I last saw him alive on Sept 30 1946.

Immediate cause of death: DIARRHOEA OF THE NEWBORN — Duration: 10 days

Due to

Due to

Other Conditions PREMATURITY — Duration: Life

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul H. Harding M.D.
Address JOHNS HOPKINS HOSP Date signed 9/30/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G44155

Please write the causes of death clearly and legibly. Physicians; please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HOWARD TAFT EASON

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1908

8. AGE: Years	Months	Days	If less than one day
38	1	24	hr. min.

9. Birthplace Wilson Co. N.C.
(Town, county, and state)
10. Usual Occupation Watch repair man
11. Industry or business May Co.

FATHER
12. Name Ernest Linwood Eason
13. Birthplace Green Co., N. C.

MOTHER
14. Maiden Name Lenora Eason
15. Birthplace Wilson Co., N. C.

16 (a) Informant J. T. Morris & Son
(b) Address 1-3 Sycamore St., Petersburg, Va.

17 (a) Removal (b) Date thereof 9/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MAPLEWOOD CEM.
Location Wilson, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Date received by registrar Huntington Williams, M.D.

OCT 1 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1946, at 10 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1946 to Sept 30 1946 and that I last saw him alive on Sept 30 1946.

Immediate cause of death Cardiac Collapse
Due to Chronic Myocarditis
Due to Cardiac Decompensation
Due to Suggestive Coronary Occlusion.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Maynard Ugent
Address Maryland Gen. Hosp. Date signed 9/30/46

G44156 BCH D57298 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G44156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 10
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 E. Chase Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME "Baby" Robinson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6, 1946

8. AGE: Years	Months	Days	If less than one day
			22 hr. 14 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business None

FATHER
12. Name Shelton Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret Dixon
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Interred
18 (a) Funeral director
(b) Address
19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar
OCT 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1946, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1946 to Sept. 7 1946 and that I last saw him alive on Sept. 7 1946

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address Johns Hopkins Hospital Date signed 9-27-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44157 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 Hyde St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 219 N Hyde St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Van Dyke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1/872

8. AGE: Years	Months	Days	If less than one day
73	9	28	hr. min.

9. Birthplace New Jersey. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Van Dyke.
13. Birthplace New Jersey.

MOTHER
14. Maiden Name Emma J Cox
15. Birthplace New Jersey.

16 (a) Informant Mrs Charles Konover
(b) Address 19 Jarvis Place Trenton N. J.

17 (a) Shipping (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery or crematory
Location Trenton N. J.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) OCT 1 1946 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Sept. 1946 at 4:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelly M.D. Medical Examiner
Date signed 30 Sept 46

G44158 BALTIMORE CITY HEALTH DEPARTMENT G44158
CERTIFICATE OF DEATH V 92E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Woodland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Pindell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Richard P. Pindell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14th 1866

8. AGE: Years 80 | Months 3 | Days 14 | If less than one day hr. min. 15

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Wm Humpld
13. Birthplace Germany

MOTHER 14. Maiden Name Katherine (Unknown)
15. Birthplace Germany

16 (a) Informant Kathryn Reich
(b) Address 3205 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) Date received by Registrar OCT 1 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1946 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1946 to Sept 29 1946 and that I last saw him alive on Sept 29 1946.

Immediate cause of death Anuria Cystitis — Duration 27h.

Due to Myocarditis — 7dy

Due to Chronic Cardiac Hypertrophy — 7dy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H L De Barker
Address 4723 Park Heights Ave Date signed 9/30/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44159 BC# 57182 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G44159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John Street & Lafayette Ave.
(c) Hospital or Institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 20 hours 45"

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 East 29th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl "B" Hoefer

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Newborn

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 20 hr. 45 min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation New born

11. Industry or business

FATHER 12. Name Edward Leroy Hoefer

13. Birthplace Portland Oregon

MOTHER 14. Maiden Name Elizabeth Abbott Spurlin

15. Birthplace Baltimore Maryland

16 (a) Informant Mother (Elizabeth A.S. Hoefer)

(b) Address 300 East 29th Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY SEP 26 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 1 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25th 1946 at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25th 1946, to Sept 25 1946, and that I last saw him alive on Sept 25th 1946

Immediate cause of death	Duration
Prematurity Infant 24 weeks	
Due to Spontaneous Abortion	
Due to Cause unknown	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address Women's Hospital Date signed 9/27/46

VS 3

G44160

BC# 57181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G44160 Registered No.

Type or use indelible pencil. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John St & Lafayette Ave.
(c) Hospital or institution: Hospital for Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs 2"
(e) Length of stay in Baltimore (yrs., mos., or days) 16 hrs 2"

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore - 18 - (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 East 29th Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl "A" Hoffer

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Newborn

6 (b) Name of husband or wife none.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	0	16 hr. 2 min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business —

FATHER
12. Name Edward Leroy Hoffer
13. Birthplace Portland Oregon

MOTHER
14. Maiden Name Elizabeth Agnes Sparklin
15. Birthplace Baltimore Maryland

16 (a) Informant Mother (Elizabeth A.S. Hoffer)
(b) Address 300 East 29th Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 26 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 1 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24th 1946, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23rd 1946, to Sept. 24th 1946, and that I last saw h[illegible] alive on Sept. 24th 1946

Immediate cause of death Postmature infant 24 wks.

Duration

Due to Spontaneous Abortion

Due to Cord umbrosum.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Women's Hospital Date signed 9/25/46

VS 3

4161 Grave # 12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN HOYT ALVIN HASBROUCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
57 ?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 26 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 1 1946 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946, at 10.20A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpass M.D.
Medical Examiner.
Date signed 9-13-46

G44162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195C

G44162 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 Wilmert Court
(If rural give location)
(e) Citizen of foreign country? Walnut (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD HOWARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Colleaner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1910

8. AGE: Years	Months	Days	If less than one day
35	11	23	hr. min.

9. Birthplace Elm City N C
(town, county, and state)

10. Usual Occupation Elevator operator

11. Industry or business

FATHER
12. Name Richard W Howard, Sr
13. Birthplace North Carolina

MOTHER
14. Maiden Name Hattie Harley
15. Birthplace N.C

16 (a) Informant Mrs. Colleaner Howard
(b) Address 1141- Wilmer Ct.

17 (a) Burial (b) Date thereof 10-3-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) OCT 1 2 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1946, at 9.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage in mid-brain (pons)
Hypertrophy of heart
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 9/30/46

VS 181

G44163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

499732 / 50

G44163

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Dundalk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola Bolestock.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Alvin

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 10-20-02

8. AGE: Years	Months	Days	If less than one day
43	11	11	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles D. Mozingo
13. Birthplace Pa.

MOTHER
14. Maiden Name Flora Baer
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-46 (month) (day) (year)
(c) Cemetery or crematory
Location Harrisburg Pa

18 (a) Funeral director Peter Funeral Home Inc
(b) Address 4644 York Road.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 1 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct - 1 1946 at 4.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 27 1946 to Oct - 1 1946 and that I last saw h[illegible] alive on Oct - 1 1946

Immediate cause of death: Carcinomatosis — Duration: 4 MOS

Due to: Carcinoma of breast — Duration: 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter M. Sweeten M. D.
Address Johns Hopkins Hosp. Date signed 10/2/46

VS Form

G44164 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G44164 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore #19
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Madison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby boy Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex m | 5. Color or race cl | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/23/46

8. AGE: Years	Months	Days	If less than one day
			7 hr. 50 min.

9. Birthplace University Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William J Redmond
13. Birthplace Maryland

MOTHER 14. Maiden Name Estelle Redmond
15. Birthplace S.C.

16 (a) Informant
(b) Address

17 (a) _____ (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 30 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 1 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1946, at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1946 to 9/24 1946 and that I last saw him alive on 9/24 1946.

Immediate cause of death Hemorrhage into nasopharynx

Due to Syphilis -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Y. Mascenburg M.D.
Address University Hosp Date signed 9/24/46

VS 150

X

G44165 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600

G44165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day after
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day after

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Peoples

3 (b) If veteran, name war None
(c) Social Security Account No. None

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 1 hr. 25 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Bernie Peoples
13. Birthplace Bishopville, S. C.

MOTHER
14. Maiden Name Helen Rose
15. Birthplace Sumter S. C

16 (a) Informant Helen Peoples
(b) Address Baltimore Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 30 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 1 1946 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1946. 6.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1946, to Sept 25 1946 and that I last saw h[illegible] alive on Sept 25 1946.

Immediate cause of death Intracerebral Hem. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jon V Ogburn M. D.
Address [illegible] Hosp Date signed 9/26

G44166

Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

G44166
Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 Carlton St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/24/46

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Wakefield Johnson
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Elizabeth Gorman
15. Birthplace Baltimore Md

16 (a) Informant Mary Elizabeth Johnson
(b) Address 218 Carlton St, Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location University Medical School

SEP 30 1946
Commissioner of Health

18 (a) Funeral director

(b) Address

19 OCT 1 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1946, at 0050 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1946 to Sept 26 1946, and that I last saw her alive on Sept 26 1946.

Immediate cause of death	Duration
Fetal atelectasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Gorman M. D.
Address Harriet Lane Date signed 9/26/46

VS 180

4167 BC# B57091 BALTIMORE CITY HEALTH DEPARTMENT G44167

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore - 1, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Sutton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/46

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr. min.

9. Birthplace Baltimore - 1, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred Johnson, Jr.
13. Birthplace Georgia

MOTHER
14. Maiden Name Virginia Williams
15. Birthplace Georgia

16 (a) Informant Father
(b) Address 210 Sutton St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location University Medical School

SEP 30 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) OCT 1 1946 (Date rec'd by registrar) (b) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1946, at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12:15 PM 9/23/46 to 4:00 PM 9/23/1946, and that I last saw h/ alive on 9/23 1946.

Immediate cause of death: Pulmonary Edema & Asphyxia — Duration: 1 day
Due to: Prematurity (6-7 mo.)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Morrison M.D.
Address Univ. Hosp. Date signed 9/23/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44168 Over BALTIMORE CITY HEALTH DEPARTMENT G44168

CERTIFICATE OF DEATH ✓ 157M

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age. It is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days) 15 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balt. Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Coos Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl "A" Poe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1946

8. AGE: Years	Months	Days	If less than one day
0	0	0	15 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant newborn

11. Industry or business

FATHER
12. Name Edgar Allen Poe
13. Birthplace Md.

MOTHER
14. Maiden Name Bertha
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 30 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) OCT 1 1946 Huntington Williams M.D. Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1946, at ~~3:44~~ 6:28 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1946 to Sept. 21, 1946. and that I last saw her alive on Sept. 21, 1946.

Immediate cause of death Congenital tumor of neck. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. Epperson M. D.
Address Keswick Hosp. Date signed 9/30/46

W. W. Epperson

G44169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G44169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkins Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 Mallow Hill ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Witt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21-1865

8. AGE: Years	Months	Days	If less than one day
80 75	9	8	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name George Siebler
13. Birthplace Pa.

MOTHER
14. Maiden Name Evelin Kruseksomp
15. Birthplace Pa.

16 (a) Informant Mrs Alberta Sellers
(b) Address 229 Mallow Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2, 46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director George W. Farley
(b) Address Fayette St. + Fulton ave.

19 (a) (Date filed by registrar) (b) Registrar

OCT 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1946 at 8 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1946 to 9-29 1946, and that I last saw h[illegible] alive on 9-29 1946.

Immediate cause of death: Respiratory Failure — Duration
Due to Cerebral Embolism
Due to Mural thrombus & auricular fibrillation
Other Conditions Arteriosclerosis generalized.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wirt Hodges M. D.
Address St. Agnes Hosp. Date signed 9-29-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44170 Registered No. 124B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 S Belnord Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S Belnord Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marcel Rachuba

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary
6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Frances Wasowski
(b) Address 626 S.Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-46 (month) (day) (year)
(c) Cemetery or crematory St.Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 S.Ann Street

19 (a) OCT 1 - 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30TH 1946 at 7 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1946 to 9/30 1946 and that I last saw h[illegible] alive on 9/29 1946.

Immediate cause of death: Cystitis 7 Urinary Incontinence
Due to Carcinoma Urethra
Due to Uremia Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 6 40.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Esther F. Rawlowicz M. D.
Address 1076 S. East Ave Date signed 9/30/46

44171 BC# B57072 BALTIMORE CITY HEALTH DEPARTMENT G44171

CERTIFICATE OF DEATH √159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution Bair Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Jos. Assaro, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
7lb.			1 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Jos. Assaro

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Eleanor McCoy

15. Birthplace New Orleans, La.

16 (a) Informant Mother - Eleanor Assaro

(b) Address 1920 E. Lafayette Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School SEP 24 1946

18 (a) Funeral director Commissioner of Health

(b) Address

OCT 1 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1946, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1946, to 9/14 1946 and that I last saw him alive on Sept 14 1946.

Immediate cause of death Premature

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Seaman, M.D. M. D.
Address Bair Hospital Signed

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44172

BC# 57020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G44172 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "A" Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 23, 1946

8. AGE: Years | Months | Days | If less than one day: 8 hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Green
13. Birthplace Virginia

MOTHER
14. Maiden Name Irma Thorpe
15. Birthplace

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 27 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19. OCT 1 1946 (Date rec'd by registrar) Hunting for Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1946 at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23- 1946 to Sept 23 1946 and that I last saw her alive on Sept. 23 19 46.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address 1818 Broadway Date signed 9-23-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44173 DCH

D 67450

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 159

Registered No. G44173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State District of Columbia (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Ninth Street NW
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 26, 1946

8. AGE: Years | Months | Days | If less than one day: 4 hr. 40 min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Clarence Sutton
13. Birthplace

MOTHER
14. Maiden Name: Inez Clark
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School SEP 27 1946

18 (a) Funeral director: Commissioner of Health
(b) Address

19 OCT 1 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 19 46 at 6:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 19 46 to Sept. 26 19 46, and that I last saw h er alive on Sept. 26 19 46.

Immediate cause of death: Prematurity — Duration: At Birth

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: J. Russell Jordan

Address: 609 N Broadway Date signed: M 9 D 26 46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1119a

G44174 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 260 Chestnut Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Proctor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-46

8. AGE: Years | Months | Days 2 Weeks | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Proctor
13. Birthplace D.C.

MOTHER
14. Maiden Name Geneva Brown
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 27 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 1 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1946 to Sept 25 1946 and that I last saw alive on Sept 26 1946.

Immediate cause of death: DIARRHEA OF NEWBORN — Duration: 10 days

Due to

Due to

Other Conditions: PREMATURITY — Duration: Life

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H Hardy

Address Johns Hopkins Hosp Date signed 9 | M. D. 26 | 46

VS 150

44175 BCH 55702 BALTIMORE CITY HEALTH DEPARTMENT G44175

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "B" Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 23,1946

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Green
13. Birthplace Virginia

MOTHER
14. Maiden Name Irma Thorpe
15. Birthplace

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 1 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1946, at 4:28 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1946 to Sept 23 1946, and that I last saw her alive on Sept. 23 1946.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan
Address 608 N. Broadway Date signed 9-23-46 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 Whitmore ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2527 W. North Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie F. Watkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Alfonso Watkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 - 1869

8. AGE: Years 77 78 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Don't Know
13. Birthplace Don't Know

MOTHER
14. Maiden Name Don't Know
15. Birthplace Don't Know.

16 (a) Informant Mrs. Marie M. Watkins
(b) Address 1811 Whitmore ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1 - 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore Md.

18 (a) Funeral director Maguire Cook Byrd
(b) Address 1600 W. North ave.

19 (a) (Date rec'd by registrar) (b) (Registrar)

OCT 1 1946 Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1946 to Sept 28 1946 and that I last saw h alive on Sept 27 1946

Immediate cause of death Cerebral Hemorrage — Duration 9/27/46

Due to Chr. Myocarditis 1942

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Frame
Address 1663 W North Ave Date signed 9/29/46 M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-104 G44177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. G44177

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Wrzeniski-or-Bernard Wrzesinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-1-1898

8. AGE: Years	Months	Days	If less than one day
48	0	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Jacob Wrzeniski or Wrzesinski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Debows
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozaguewski
(b) Address 1930 Eastern Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH September 29- 1946, at 12.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11- 1946 to 9-29 1946 and that I last saw h im alive on 9-29 1946.

Immediate cause of death Pulmonary Tuberculosis, Far advanced Bilateral, 7 cases-Intermonthly — Duration 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 9-30-46

OCT 1 - 1946 Huntington Williams, Md.

G44178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32B

G44178 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 S Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Finn

3 (b) If veteran, name War | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12 1902

8. AGE: Years 43 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Lobster

11. Industry or business Boats

FATHER
12. Name William Finn
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Ward
15. Birthplace Ireland

16 (a) Informant Mrs Jane V. Willis
(b) Address 620 S Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 3 46 (month) (day) (year)
(c) Cemetery or crematory Bon Secours Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John Conway Sons
(b) Address 401-403 Gallows St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946, at 9:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1946 to Sept 29 1946, and that I last saw h[illegible] alive on Sept 29 1946.

Immediate cause of death
Endocarditis — Duration 1 week

Due to Influenza — 1 week

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature C B Welch M. D.
Address 1279 Fulton N Date signed 9/30/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13B

G44179 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Information supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 S. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 S Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Ropan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1917

8. AGE: Years	Months	Days	If less than one day
29	8	28 27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name John J. Ropan
13. Birthplace Ireland

MOTHER
14. Maiden Name Delia E. Woods
15. Birthplace England

16 (a) Informant John J. Ropan
(b) Address 642 S. Payson St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 911-13 Hollins St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28th 1946 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Sept 28 1946, and that I last saw him alive on Sept 28 1946.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions Pulmonary Tuberculosis Chronic Interstitial Enteritis Cachexia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Martin, Jr. M. D.

Address 1933 Eutaw St. Date signed 9/30/46

X

G44180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

357238 159

Registered No. G44180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balto Gen'l Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2157 Mt Holly St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1946.

8. AGE: Years	Months	Days	If less than one day
			1 hr. 40 min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard Earl Fleming
13. Birthplace Wallace, W. Va.

MOTHER
14. Maiden Name Doris Elizabeth Weems
15. Birthplace Owensboro, Ky.

16 (a) Informant Doris Fleming
(b) Address 2157 Mt Holly, St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 24 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 1 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946 at 8^45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Sept 19 46 to 19 Sept 19 46 and that I last saw h / alive on 19 Sept 19 46.

Immediate cause of death Prematurity (6 months) — Duration

Due to Hemorrhagic disease Purpura Diffusis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cohen M. D.
Address South Balto Gen'l Hosp Date signed 21 Sept 46

VS 150

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

G44181

BC# 356828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157H

G44181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St. 15
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 + Fleetwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mayo Victor De Ruggiero

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 7D. Months Days If less than one day hr. 25 min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Victor De Ruggiers
13. Birthplace Naples, Italy

MOTHER 14. Maiden Name Mary Grand Paradiso
15. Birthplace New York, N.Y.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 24 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 1 1946 (b) H. Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946 at 2.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Bilateral Polycystic Kidneys — Duration ?

Due to

Due to

Other Conditions Bilateral Club Foot — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral Polycystic Kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney Lanier M. D.
Address 2240 Eutaw Place Date signed 9-30-46

VS 180

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44182

OC# 95746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G44182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT STREET
(c) Hospital or institution: SOUTH BALTIMORE GEN. HOSP. No 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 34 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 S BOULDIN ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SHARON LEA NORANBROCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-21-46

8. AGE: Years | Months | Days 1½ | If less than one day hr. min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name CHARLES WILLIAM NORANBROCK

13. Birthplace BALTIMORE, MD

MOTHER 14. Maiden Name DOROTHY ELIZABETH NOEL

15. Birthplace BALTIMORE, MD

16 (a) Informant DOROTHY NORANBROCK

(b) Address 827 S. BOULDIN ST

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School SEP 24 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 1 1946 (Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 SEPT 1946, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1946 to 9/22 1946 and that I last saw her alive on 9/21 1946

Immediate cause of death: Prenatal Injury (6½ mos gravid) — Duration

Due to: Premature Labor

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cohen M.D.

Address 3rd Balto Co. Date signed 9/24/46

VS 190

Correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

G44183 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G44183 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4832 Wright Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lavender

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-46

8. AGE: Years	Months	Days	If less than one day
Premature			9 hr. 20 min.

9. Birthplace Maryland J.H.H.
(town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Lavender
13. Birthplace Maryland

MOTHER
14. Maiden Name Joyce Wallace
15. Birthplace Maryland

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 23 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 1 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15- 1946 at 4 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13- 1946 to 9-15- 1946 and that I last saw h alive on 9-13- 1946

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan
Address 800 N Broadway Date signed 9-16-46

VS 150

G44184

BC# 67003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

G44184 Registered No.

Type or use ink. Spell out all words. Do not abbreviate. Give the causes of death clearly and legibly. Physicians: please write the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. Overbrook Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Webb.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 23 hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Webb

13. Birthplace [illegible]

MOTHER 14. Maiden Name Pamelia Amory

15. Birthplace Canada

16 (a) Informant Friends

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School SEP 23 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 1 1946 (Date rec'd by registrar) (b) Harrington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept - 20 1946, at 2.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept - 19 1946, to Sept - 20 1946, and that I last saw h[illegible] alive on Sept - 20 1946.

Immediate cause of death: Erythroblastosis fetalis — icterus gravis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address 5 of N Broadway Date signed 9-20-46

VS 150

44185 BC# B57002 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G44185

CERTIFICATE OF DEATH 157M

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elmo

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 18, 1946

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Leroy Elmo
13. Birthplace Maryland

MOTHER
14. Maiden Name Hazel Lang
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 23 1946

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 1 1946 (Date rec'd by registrar) Huntington Hillcoat, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1946, at 12:20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18- 1946 to 9-20 1946, and that I last saw him alive on 9-20- 1946

Immediate cause of death	Duration
Fetal abnormality, congenital	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Russell Jordan M. D.
Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G44186

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 1310

G44186 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the information requested. This item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 Oxford Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Oxford Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ARTHUR WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1885

8. AGE: Years	Months	Days	If less than one day
60	10	12	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George R. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Rosa Duckett
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Williams Key
(b) Address 529 Oxford Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) OCT 1 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1946, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 3 1946 to Sep 29 1946 and that I last saw h alive on Sep 28 1946

Immediate cause of death — Duration

Due to Pulmonary Edema

Due to Myocarditis Chr.

Due to Nephritis Chr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Haviland M. D.
Address 601 N. Carrollton Ave. Date signed 10/1/46

VS 150

G44187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63c ✓

G44187 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Whitney Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Whitney Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee F. Curran, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Anna Curran,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1883

8. AGE: Years 63 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Bookkeeper,

11. Industry or business Uniform Mfg.

FATHER
12. Name William Curran,
13. Birthplace Penna.

MOTHER
14. Maiden Name Elizabeth Williamson,
15. Birthplace Baltimore.

16 (a) Informant Mrs. Anna Curran,
(b) Address 2502 Whitney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City,

18 (a) Funeral director H. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1946 at 3:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1946 to 9/29 1946 and that I last saw him alive on 1946

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arterio Sclerosis	
Due to	
Other Conditions Hyperthyroidism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Curran M. D.
Address 5611 Old Pimlico Road. Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1946 Huntington Williams, M.D.

X

G44188 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G44188

CERTIFICATE OF DEATH

121 Registered No.

Use write the causes of death clearly and legibly. Physicians: please write correct age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert - Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr. 2 do

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Towson 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Alabama Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George John Lochner, (Sr.)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16 - 1927

8. AGE: Years	Months	Days	If less than one day
19	0	1/14	hr. min.

9. Birthplace Balt. - Balt. Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Mr. George J. Lochner
13. Birthplace Md. (Balto.)

MOTHER
14. Maiden Name Margaret C. Mundy
15. Birthplace Pa. (Elgin)

16 (a) Informant Mrs. George Lochner
(b) Address 414 alabama Rd. Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Maria Cem.
Location Towson, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Bal[illegible]., Md.

19 (a) Date received by Registrar OCT 1 1946 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1946, at 4 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1946 to 9-30 1946 and that I last saw h[illegible] alive on 9-30 1946.

Immediate cause of death	Duration
(a) Cardiac failure	6 hrs
Due to Hyperpyrexia	24 hrs
Due to Peritonitis Septicemia	6 days 2 days 2 days 14 hrs
Other Conditions Intest. obst. Fecal fistula	

(Include pregnancy within 3 months of death)
Date of operation Appendectomy
Major findings of operation: Acute Supp. appendicitis - ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dr. Lothum, Thomas A.
Address Mercy Hosp. Date signed 9/30 M.D.

Lothum X

G44189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1313

G44189 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James S. Keller

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Elizabeth C. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1874

8. AGE: Years 72 | Months 1 | Days 2 | If less than one day: hr. min.

9. Birthplace Balto. County (Town, county, and state)

10. Usual Occupation Retired Letter Carrier

11. Industry or business

FATHER
12. Name Henry Keller
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Stevenson
15. Birthplace Balto. County

16 (a) Informant Mrs. Elizabeth C. Keller
(b) Address 511 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery Parkwood
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1946, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10th. 1946 to Sept. 28th 1946. and that I last saw him alive on Sept. 27th 1946.

	Duration
Immediate cause of death: Uremia	1½ days
Due to: Chronic Parenchymatous Nephritis	unknown
Due to:	
Other Conditions: Hypertrophy of Prostate (Include pregnancy within 3 months of death)	about 5 years.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Murgatroyd M.D.
Address 401 E. 25th. St. Date signed 9/30/46.

GEO. W. MURGATROYD, M.D.

VS 150

G44190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44190 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5730 Pennington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5730 Pennington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE ELMER BELL, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	218-09-9136

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Elizabeth V. Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1863

8. AGE: Years	Months	Days	If less than one day
82	9	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Ass't. Chief Police
11. Industry or business U. S. Industrial Chem. Co.

FATHER
12. Name - Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Laura V. Prince
15. Birthplace Md.

16 (a) Informant Mrs. Rose L. Mack
(b) Address 5730 Pennington Ave.

17 (a) Burial (b) Date thereof 10/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 1 - 1946 (b) Huntington Hitchcock, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1946, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Sept 30 1946, and that I last saw him alive on Sept 30 1946

Immediate cause of death: coronary occlusion — Duration

Due to: hypertension, cardio-vascular dis.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ph. Keister, MD
Address 302 Patapsco Ave Date signed 10/1/46
Philip Keister

VS 150

G44191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G44191

Please write the cause of death clearly and legibly. Physicians: please correct age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 N. Denison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N. Denison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Henry Harman

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Clara Marie Harman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1876

8. AGE: Years	Months	Days	If less than one day
70	3	12	hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name William Harman
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Mary Laynor
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Clara Marie Harman
(b) Address 424 N. Denison St.

17 (a) Burial (b) Date thereof 10.2.46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 1 - 1946 (b) Huntington Hillsman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 30, 1946 at 12:27 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Sept 29 1946 and that I last saw h[illegible] alive on Sept 29 19 46

Immediate cause of death
Coronary Thrombosis
1 hour Intestinal
Due to Fractu

Duration

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury
23. Signature John A Evans M. D.
Address 612 N 40 St Date signed

VS 150

G44192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G44192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 St. John Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 St. Johns Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOE CURTIS TRIBBLE GUYTON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth Neikirk Guyton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1905

8. AGE: Years 41 | Months 0 | Days 29 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Treasury Dept.

FATHER
12. Name Clarence Lee Guyton, Sr.
13. Birthplace Williamson, S. C.

MOTHER
14. Maiden Name Addie Duckworth
15. Birthplace S. C.

16 (a) Informant Mrs. Ruth H. Guyton
(b) Address 610 St Johns Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 1 - 1946 (Date rec'd by registrar) (b) Huntington Hillegeas, M.D. Registrar

VS 19t

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1946, at 7.40 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bilateral Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallezis M.D.
Medical Examiner.
Date signed 9-30-46

44193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G44193

Type or use ink; if certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1548 Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1548 Penna ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Hansen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	W

6 (b) Name of husband or wife Victoria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1872

8. AGE: Years	Months	Days	If less than one day
73	9	1	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Nelson Hansen
13. Birthplace Md

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Melvin Hansen
(b) Address 1926 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pressman St

19 (a) OCT 1 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946 to Sept 24 1946, and that I last saw h alive on Sept 24 1946.

Immediate cause of death: Acute Dilatation, Cardiac Dilatation of Left Ventricle Regurgitation

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H M Hall M. D.
Address 10/1/46 Date signed 10/1/46

G44194 ✓ G44194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No.

Please write the causes of death clearly and legibly. Cancer is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 George St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KING SOLOMON

3 (b) If veteran, name war

3 (c) Social Security Account No. 917-07-6782

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	M

6 (b) Name of husband or wife Ellis Carinda Soloman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-02

8. AGE: Years	Months	Days	If less than one day
43	9	4	hr. min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation Truckman

11. Industry or business Penna. R.R.

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Chas C. Solomon
(b) Address 804 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) Oct 1 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Sept. 1946, at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Sept 1946 to 29 Sept 1946 and that I last saw h[illegible] alive on 29 Sept 1946

Immediate cause of death Respiratory failure — Duration

Due to Meningitis

Due to tuberculous (+ culture)

Other Conditions Pt. had Lt Mast Kahn doubtful CSF Kahn
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James O'Hare M. D.
Address Lafayette Hosp. Date signed 9/29/46

G44195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G44195 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 14 Division St.
(c) Hospital or institution: Provident Hosp. (If not in hospital or institution, give residence)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 818 W. Mulberry St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Molden.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Negro. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Molden.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1870

8. AGE: Years 76. | Months - | Days 26 | If less than one day hr. min.

9. Birthplace Essex Co. Va. (Town, county, and state)

10. Usual Occupation Home wife.

11. Industry or business None.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Lucy Holmes.
15. Birthplace unk

16 (a) Informant Mrs. Mary Robinson.
(b) Address 818 Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27/46, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26/46 to 9/27/46, and that I last saw h alive on 9/27/46.

Immediate cause of death Diabetic Gangrene of both feet
Due to Diabetic Mellitus

Due to

Other Conditions Senility.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Provident Hosp. 14 Division St. Date signed 9/30/46

Correct cause of death clearly and legibly. Physicians: please write especially important.

G44196 BALTIMORE CITY HEALTH DEPARTMENT G44196

CERTIFICATE OF DEATH (567)

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 348 Savannah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Betz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years	Months	Days	If less than one day
	3		hr. min.

9. Birthplace Essex, Balto. County, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marion Betz
13. Birthplace Md.

MOTHER
14. Maiden Name Hilda Schadle
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 348 Savanah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location O'Donnell St.

18 (a) Funeral director John P Connelly
(b) Address 41 Eastern Ave. Essex

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 1 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1946, at 9 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1946, to 9/30 1946 and that I last saw him alive on 9/30 1946.

Immediate cause of death Post-operative Pulmonary Edema after Craniotomy for Removal of Papilloma of Choroid Plexus by Left Lateral ventricle — Duration 2 Hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/26/46

Major findings of operation: Papilloma of Choroid Plexus - Left Lat. Ventricle

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Marmon

Address Univ. Hosp. Date signed 9/30/46

G44197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44197 Registered No.

Use the causes of death clearly and legibly. Physicians: please write plainly, especially surnames. Do not abbreviate.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 S. Conkling Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 9
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 S. Conkling Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANTONIA JOSKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph Joska
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1873

8. AGE: Years	Months	Days	If less than one day
72 yrs.	9	5	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Nebohy
13. Birthplace Czech.

MOTHER
14. Maiden Name BACKOVSKY
15. Birthplace Czech.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horners Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) OCT 1 - 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1946 at 12 15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 20 1943 to Sept 29 1946 and that I last saw her alive on Sept. 29 1946.

Immediate cause of death Coronary Thrombosis — Duration 2 hours
Due to Coronary Sclerosis
Due to
Other Conditions Myocardial Degeneration
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Vincent F. Joska M.D. M. D.
Address 845 N. Paca, Balto Md. Date signed 10/1/46

G44198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110 B

G44198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 E. Chase St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JACQUELINE FRANCES HAHN

3 (b) If veteran, name war
3 (c) Social Security Account No. None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1939

8. AGE: Years	Months	Days	If less than one day
6	11	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name James Hahn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alfreda Lutrzyhowski
15. Birthplace Baltimore, Md.

16 (a) Informant Parents
(b) Address 2406 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) 10-1-1946 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946, at 11:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946 to Sept 29 1946 and that I last saw her alive on Sept 29 1946

Immediate cause of death Cardiac failure — Duration

Due to Lymphosarcoma, hydrothorax, hydropericardium, hydrothorax, ascites — Duration

Due to Nephrosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 9-29-

Contagious disease is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G44199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

G44199
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23. S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 S Conkling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20-1882

8. AGE: Years 63 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county or state)

10. Usual Occupation Retired Police Officer

11. Industry or business Balto. City Police

FATHER
12. Name John H. Myers
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret F. Wallenwein
15. Birthplace Balto. Md.

16 (a) Informant Sophia Myers
(b) Address 23 S. Conkling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3/46 (month) (day) (year)

(c) Cemetery or crematory Balto
Location E. Nth. Ave

18 (a) Funeral director John A. Mahan
(b) Address 3000 E. Balto. St

19 [illegible] Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1946 to Sept 29 1946, and that I last saw h[illegible] alive on Sept 28 1946.

Immediate cause of death
Coronary Thrombosis
Due to Arteriosclerosis
Due to Hypertension

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robt Buckley M. D.
Address 936 E Balto Date signed 9-23-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

G44200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 Valley street
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME MARY A. DOHONY √

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband ~~or wife~~ Thomas J. Dohony

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	28	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Joseph Rigney
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary M. Lewin
(b) Address 1026 Valley street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

OCT 1 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946, to Sept 27 1946, and that I last saw her alive on Sept 27 1946.

Immediate cause of death	Duration
Acute Bronchial Pneumonia	
Due to	
Due to Arteriosclerosis	
Other Conditions Acute Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. A. Hornstein M. D.
Address 733 Augusta St Date signed 10/1/46

X

G44201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44201 Registered No. 1706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19th D.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 522 N. Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Jason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1912

8. AGE: Years	Months	Days	If less than one day
34	5	6	hr. min.

9. Birthplace Howard County Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Jason
13. Birthplace Howard Cauty Maryland

MOTHER
14. Maiden Name Jane Robinson
15. Birthplace Carroll County Maryland

16 (a) Informant Samuel Jason
(b) Address 3 N. Shroeder Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore city

18 (a) Funeral director Joseph A. Lively
(b) Address 640 West Dare Street

19 (a) OCT 1 - 1946 (Date rec'd by registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1946 at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed pelvis, Bilateral rupture of diaphragm

Due to

Other Conditions Hemothorax and Hemoperitoneum; lacerations, bruises, and simple fract. of leg bone (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7:30 P.M. 9/27/46
(b) Where did injury occur? Carroll & Stricker
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped struck by trackless trolley

23. Signature Howard J. [illegible] M.D. Medical Examiner.
Date signed 9-28-46

VS 151

C44202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

R C44202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Register St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT D. SVEZZESE

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 214-16-5020

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1921

8. AGE: Years	Months	Days	If less than one day
25	2	15	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Oil refitter Helper
11. Industry or business

FATHER
12. Name Nicola Svezzese
13. Birthplace Italy

MOTHER
14. Maiden Name Clara Ferracci
15. Birthplace Baltimore, Md

16 (a) Informant Clara Ferracci (mother)
(b) Address 108 S. Register St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-46 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Rd - Balt. Md

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Mosley St

19 (a) OCT 1 - 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1946 at 12.01 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Congenital bicuspid aortic valve
Subacute bacterial endocarditis of aortic valve
Due to
Occlusion of mouth of left coronary artery by bacterial vegetations.
Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. (Medical Examiner)
Date signed 9/30/46

G44203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1823

G44203 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 West 24th Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANCIS WINN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1888

8. AGE: Years	Months	Days	If less than one day
58	2	16	hr. min.

9. Birthplace Scranton, Pa. (Town, county, and state)

10. Usual Occupation Feed mill

11. Industry or business

FATHER
12. Name Patrick Winn
13. Birthplace Ireland.

MOTHER
14. Maiden Name Anna Regan
15. Birthplace Ireland

16 (a) Informant Nettie Winn
(b) Address 6 W. 24th St.

17 (a) (Burial, cremation, or removal) **(b) Date thereof** 10/5/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Scranton Pa.

18 (a) Funeral director Thomas J. Kenny Co.
(b) Address Holland & Gilmore

19 (a) OCT 1 1946 **(b)** Huntington Wittiers, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1946, 10.10 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
Dislocation of Cervical Vertebra

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2101 E. Fort Ave 24/1
(a) Date of injury 9-30 After 4:45 P.M.
(b) Where did injury occur? Scranton Steatite Corporation Mills
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from tunnel 40 to 50 ft. Came to Chicken feed

23. Signature Howard J. Weinlein M.D.
Medical Examiner.

Date signed 10-1-46

X

G44204 BCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

B55418 / 159

G44204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby / Milton Quinn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31, 1946

8. AGE: Years | Months | Days 30 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Baby

FATHER
12. Name John A. Amos
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Evelyn Quinn
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md

18 (a) Funeral director A. Abalotad
(b) Address 918 Druid Hill Ave.

19 OCT 2 - 1946 (a) Huntington Williams, M.D.
(Date filed by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1946, at 4:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1946 to Sept. 30 46, and that I last saw h. alive on Sept 30 19 46.

Immediate cause of death: Biliary anomaly — Duration

Due to

Due to

Other Conditions Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address 809 N. Broadway Date signed 9-30 46

VS 150

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

G44205

CHK-66139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G44205 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 10- 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Had no home. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15- [redacted] 1878

8. AGE: Years 68 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Coal carrier

11. Industry or business Unemployed

FATHER 12. Name [redacted] Norris

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret ?

15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46 (month) (day) (year)

(c) Cemetery [redacted] Mt. Calvary

Location Cedar Hill Md

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 DEC 2 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1946; at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1943 to Sept. 30 1946 and that I last saw him alive on Sept. 30 1946

Immediate cause of death: Bronchopneumonia — Duration: 3 days

Due to

Due to

Other Conditions Generalized Arteriosclerosis — Duration: 2 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Bronchopneumonia, Arteriosclerosis

PHYSICIAN

Underline the cause, to which death should be attributed

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. Robinson Jr. M. D.

Address Balto. City Md. Date signed 10/1/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44206 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G44206

Write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Walker Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Iacaboni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife (None)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1946

8. AGE: Years	Months	Days	If less than one day
			hr. 50 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation (Newborn)
11. Industry or business

FATHER
12. Name Camillo Iacaboni
13. Birthplace Italy

MOTHER
14. Maiden Name Anna D'Miolis
15. Birthplace Brazil

16 (a) Informant Camillo Iacaboni
(b) Address 507 Walker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Baltimore Md

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Hanley St

OCT 2 - 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept Oct. 1 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1946 to Oct 1 1946, and that I last saw her alive on Oct. 1 1946

Immediate cause of death: Strangulation; - mechanical obstruction
Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None (Monstrosity)

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Sheehan M.D. H.B. Munson M. D.
Address Mercy Hospital Date signed Oct. 1, 46

VS 150

G44207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G44207 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4503 Schley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4503 Schley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Geo. H. Thomas

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov 1 1871

8. AGE: Years 74 | Months 10 | Days 22 | If less than one day hr. 23 min.

9. Birthplace White Stone Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Andrew Martens

13. Birthplace Germany

MOTHER 14. Maiden Name Mata Von Klahn

15. Birthplace Germany

16 (a) Informant Rev. Geo. H. Thomas

(b) Address 4503 Schley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1, 46 (month) (day) (year)

(c) Cemetery or crematory Immanuel

Location Harford Rd.

18 (a) Funeral director L. Hessmann & Son

(b) Address 32 S. Broadway.

19 (a) OCT 2 - 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29. 1946. at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Sept. 29 1946, and that I last saw h[illegible] alive on Sept. 24 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 1 Hour

Due to Hypertensive Cardio-Vascular Disease — 4 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Hersperger

Address 214 Medical Art. Bldg. Date signed 9/30/46

VS 186

G44208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44208 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 No. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ruth Edmunds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Aug 6 - 1883

8. AGE: Years 63 | Months -1 | Days 24 | If less than one day — hr. — min.

9. Birthplace Petersburg Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Norfleet M Haisty
13. Birthplace North Carolina

MOTHER
14. Maiden Name Roberta Haisty Bashlo
15. Birthplace North Carolina

16 (a) Informant Mary Edmunds (son)
(b) Address 13 No. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Charles S Towell
(b) Address 2427 Edmondson Ave

19 Oct 2 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1946, at 5.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1946 to Sept 30 1946, and that I last saw h[illegible] alive on Sept 30 1946.

Immediate cause of death: Acute pulmonary oedema

Due to: Left Heart Failure

Due to:

Other Conditions: Coronary Thrombosis Hypertension
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

Autopsy:

Duration
5th P.M.
5.10 P.M.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams
Address Franklin Sq. Hosp. Date signed 10/1/46

VS 150

G44209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44209
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write especially important. Correct Age if

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3801 8th St (25 Zone 5)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 1a

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 3801 8th St Baltimore Md (25)
(If outside U. S. and Canada, give country)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Hutchinson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sarah Hutchinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27-1874

8. AGE: Years 72 Months -1 Days -5 If less than one day hr. min.

9. Birthplace New Brunswick N.J.
(Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business Penn. R.R. Co

FATHER 12. Name Issac Hutchinson

13. Birthplace N.J.

MOTHER 14. Maiden Name Ida Sutphen

15. Birthplace N.J.

16 (a) Informant Mrs. A. H. Kevhyedian

(b) Address 3801 8th St (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5-46 (month) (day) (year)

(c) Cemetery or crematory Elm Ridge Cem

Location Trenton N.J.

18 (a) Funeral director Milton Schilling

(b) Address 3914 Hanover St

19 Filed Oct 2 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1946 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 1 1946 and that I last saw him alive on Oct 1 1946.

Immediate cause of death Coronary Heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Valaster Ave Date signed

VS 180

G44210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G44210 Registered No.

Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Ascension Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Elsie Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Married

6 (b) Name of husband or wife: Milford Edwards
6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.) May 12, 1916

8. AGE: Years	Months	Days	If less than one day
30	4	18	hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: David Henderson
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Sarah Hannah
15. Birthplace: Virginia

16 (a) Informant: Hospital Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Md.

18 (a) Funeral director: Fred H. Belson
(b) Address: 1303 Pennsylvania Ave

19 (a) (b) Registrar

(Registered by registrar) OCT 2 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 19 46 at 9:12A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 19 46 to Sept. 30 19 46 and that I last saw her alive on Sept. 30 19 46.

Immediate cause of death: Heart failure — Duration: [illegible]
Due to: Pulmonary Fibrosis — Duration: [illegible]
Due to: Boecks Sarcoid — Duration: [illegible]
Other Conditions: Pregnancy delivered abortion — Duration: [illegible]
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Nicholson T. Eastman M. D.
Address: Johns Hopkins Hospital Date signed 9-30-46

G44211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44211 Registered No.

Write the causes of death clearly and legibly. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 2404 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Goldon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mrs Goldon — Son
(b) Address 2916 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Park Rd + Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St.

19 (a) OCT 2- 1946 (Registered by registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1946, at 3.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1946 to 10-2 1946 and that I last saw h[illegible] alive on 10-2 1946

Immediate cause of death: Chr. card. v.a. disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edmund Reeves
Address Reisterstown Date signed 10/2/46

VS 190

X

G44212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44212
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Iona Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Iona Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary McGinnety

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Bernard J. McGinnety
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1871

8. AGE: Years	Months	Days	If less than one day
75	0	4	~~11 hrs. 11~~ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Arthur O'Keeffe
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth O'Keeffe
15. Birthplace Ireland

16 (a) Informant Miss. Elizabeth V. McGinnety
(b) Address 3014 Iona Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Memorial Park
Location Taylor Avenue, Balto. Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (b)

Date rec'd by registrar OCT 2 1946 Registrar

VS 150

Correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1946 to 9/30 1946, and that I last saw her alive on 9/30 1946.

Immediate cause of death	Duration
Increased Intracranial Pressure	5 days
Due to Cerebral Hemorrhage	2½ wks.
Due to Arteriosclerosis	
Other Conditions Arteriosclerotic Heart Disease	16 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K. Lueberry M. D.
Address 2116 W. Pratt St. Date signed 10/1/46

82a

G44213 — BALTIMORE CITY HEALTH DEPARTMENT — G44213

CERTIFICATE OF DEATH

#99827. ✓92 B — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1237 W. King St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold Ziegler.

3 (b) If veteran, name war

3 (c) Social Security Account No. 198-03-[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	White.	married

6 (b) Name of husband or wife Betty Ziegler
6 (c) If alive, [illegible] age 26 years

7. Birth date of deceased (mo., day, yr.) 3-5-19.

8. AGE: Years	Months	Days	If less than one day
27.	6	27	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business

FATHER
12. Name Clark Ziegler
13. Birthplace Pa.

MOTHER
14. Maiden Name Ora. Dietz
15. Birthplace Pa

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-46 (month) (day) (year)
(c) Cemetery or crematory Luthern Cem. Location Shrewsbury, Pa.

18 (a) Funeral director J. M. Schandelmeier
(b) Address York Pa.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 2 1946

VS 750

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 1 1946, at 7.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1946, to Oct 1 1946, and that I last saw him alive on Oct 1 1946.

Immediate cause of death Cardiac failure — Duration

Due to Subacute bacterial endocarditis of mitral and aortic valves

Due to Rheumatic heart disease with mitral and aortic stenosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Austrian
Address Johns Hopkins Hosp Date signed 10-2-46

X

396.99 G44214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139a

G44214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5-31 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-17-1883

8. AGE: Years 63 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name Joe Johnson
13. Birthplace Virginia

MOTHER 14. Maiden Name Anna Roberts
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Smithfield Baptist
Location Smithfield, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave.

19 (a) (Date filed by registrar) (b) Huntington Williams M.D. Registrar

1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1946, at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1946, to 9-29 1946, and that I last saw h[illegible] alive on 9-29 1946.

Immediate cause of death: Cardiac failure, left sided, + pulmonary edema — Duration
Due to: Hypertensive C-V disease chronic
Due to:
Other Conditions: Moderate dickation

(Include pregnancy within 3 months of death)

Date of operation 9-24-46
Major findings of operation: Pelvic abscess chronic, + pyosalpinx, rt.
of autopsy: Paralytic ileus, mod.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bruce J. Strang M.D.
Address Johns Hopkins Hosp. Date signed 9-30-46

VS 150

X

G44215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44215 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEOLA IRENE MERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1895

8. AGE: Years	Months	Days	If less than one day
51	7	14	hr. min.

9. Birthplace Vella, Mo. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Irvington Drug Store

FATHER
12. Name John Upton
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Cavey
15. Birthplace Md.

16 (a) Informant Mrs. Louis Lucas
(b) Address 3703 Woodbine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Ellicott City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 2 1946 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1946 at 11 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Sept 29 1946, and that I last saw her alive about July 1946.

Immediate cause of death
Cerebral Hemorrhage — Duration 3 Days

Due to Hypertension Cardiac

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 3321 Fred. Ave Date signed 10-2-46

VS 150

G44216

BALTIMORE CITY HEALTH DEPARTMENT

G44216 CERTIFICATE OF DEATH 1937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 N Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give name of county)
(d) Street No. 1605 N Fulton Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Alma (~~Davis~~) Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, widowed, or ~~divorced~~. Widow

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1876

8. AGE: Years	Months	Days	If less than one day
70			..... hr. ..... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business .

FATHER
12. Name ?
13. Birthplace .

MOTHER
14. Maiden Name ?
15. Birthplace .

16 (a) Informant ?
(b) Address .

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2nd 1946 (month) (day) (year)
(c) Cemetery or crematory St Matthews
Location O'Donnell St Ext

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N Patterson Park Ave

19 (a) Registered by (name) (b) Registrar
Oct 2 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Sept 1946 at 11:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Jan death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular Cardio Vascular Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature William G Hitchcock M.D.
Medical Examiner.
Date signed 30 Sept 46

G44217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G44217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dna
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lennie A. Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Rosie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-9-1894

8. AGE: Years 51 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Portsmouth, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Louis Young
13. Birthplace Va.

MOTHER 14. Maiden Name Rosie Young
15. Birthplace Va.

16 (a) Informant Rose Young
(b) Address 12 N. Poppleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn cem
Location Baltimore, Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) OCT 2 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION 22

20. DATE OF DEATH October 1, 1946, at 12 p. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rupture esophageal varicis, Cirhosses of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 10-2-46

G44218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V128

Registered No. G44218

Please write the causes of death clearly and legibly. Physicians: please write the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen Hosp- 1 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. Fetzer (Fred Fetzer)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Rosa Fetzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	5	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Rosa Fetzer
(b) Address 107 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd

18 (a) Funeral director Harry H. Nitkin
(b) Address 1101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Washington Nitkin Williams, M.D. Registrar

OCT 2 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1946 at 11:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Sept 30 1946 and that I last saw h[illegible] alive on Sept 30 1946;

Immediate cause of death Asphyxia due to aspirating vomitus in Lungs. — Duration

Due to Partial Denture Obstruction

Due to Peritonitis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Acute Hemorrhagic Pancreatitis & Necrosis of adjacent fat

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil R. Barnes
Address West Balt. Gen Hosp Date signed 10/1/46 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

122 h

G44219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44219 Registered No.

Please write the causes of death clearly and legibly. Physicians: please see that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry & Payne Aves.
(c) Hospital or institution: West Balto. Gen'l. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Longwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS J. JENNINGS - Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Married

6 (b) Name of husband or wife Florence M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1877

8. AGE: Years	Months	Days	If less than one day
69	0	0	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Balto. City

FATHER
12. Name John J. Jennings
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jane
15. Birthplace Ireland

16 (a) Informant Clarence M. Jennings
(b) Address 707 N. Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry N. Tuttle
(b) Address 4101 Edmondson Ave

19 (a) (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1946 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1946 to Sept. 30 1946 and that I last saw h. alive on Sept. 30 1946

Immediate cause of death	Duration
Acute Pulmonary Edema	12 hrs.
Due to Coronary artery Sclerosis	6 yrs. ?
Due to Coronary arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Corroboratory.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leonard E. Blumenthal. M. D.
Address WBGH. Date signed 9/30/46

VS 180

G44220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1340

G44220
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Foster Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. John W. Rehmannona

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/21/89

8. AGE: Years 57 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Brakesman

11. Industry or business Rail Road

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Elizabeth Rehmannona
(b) Address 3712 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director Tully & Zeile Inc
(b) Address 403 S. Wolfe St.

19 (a) Date of [illegible] 1946 Hunting for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/46 19 , at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7/46 19 , to 9/29/46 19 and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration

Due to Phlebothrombosis (Rt. leg)

Due to Renal Calculi

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Kurtz Sellers M.D.
Date signed 9-30-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Dr. Sheloran
7122 Harford Rd.

G44221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓49a

Registered No. G44221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Glenmore Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Glenmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isolina M. Stipa

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Gurrno Stipa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1900

8. AGE: Years	Months	Days	If less than one day
46	8	2	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Francis Mazzaccki
13. Birthplace Italy

MOTHER
14. Maiden Name Julia ?
15. Birthplace Italy

16 (a) Informant Mr. Gurrno Stipa
(b) Address 3501 Glenmore Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) OCT 2 1946 (b) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1946 at 12 hour M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Aug 1946 to 1 Oct 1946, and that I last saw h[illegible] alive on 1 Oct 1946

Immediate cause of death	Duration
Intestinal obstruction	1 month
Due to Generalized carcinoma 40 Sis	9 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Sheloran
Address 7122 Harford Rd Date signed 2 Oct 46 M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G44222

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 W. Clement (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Flack

3 (b) If veteran, name war —

3 (c) Social Security Account No. ✓

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/96

8. AGE: Years 50 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James J Murray
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Norton
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John Flack
(b) Address 125 W. Clement St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J Cannon & Son
(b) Address 901-03 Hollins St.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

OCT 7 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Oct. 1946 at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Sept 1946 to 1 Oct 1946. and that I last saw h[illegible] alive on 1 Oct 1946.

Immediate cause of death Hemorrhage — Duration

Due to Ulcer of Chest

Due to Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. McAuliffe M.D.

Address Date signed

X

G44223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G44223

Please write the causes of death clearly and legibly. Physicians: please report age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Stamford Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Stamford Road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William Ricks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mary F. Orem
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 23, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foreman-United Railways
11. Industry or business Retired - 15 years

FATHER
12. Name John W. Ricks
13. Birthplace ?

MOTHER
14. Maiden Name Clarissa Shipley
15. Birthplace Howard County, Md.

16 (a) Informant Mrs. Laura Ricks Horner
(b) Address 511 Stamford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by registrar) (b) Registrar

OCT 2 1946 Huntington, Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1946, at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Sept 30 1946 and that I last saw h[illegible] alive on Sept 29 1946.

Immediate cause of death: Cardiac failure — Duration

Due to: Arteriosclerosis & Hypertensive Cardiovascular Renal disease

Other Conditions: Contributory to popliteal artery

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. Abrafsky M. D.
Address 601 N. Monroe St. Date signed 10/1/46 M. D.

G44224 G44224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town Claiborne
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Price, Percy Carroll

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Price
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1876

8. AGE: Years 69 | Months 10 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Purser
11. Industry or business Seafarer

FATHER
12. Name Wm. J. Price
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4/46 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton, Md.

18 (a) Funeral director John D. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place,

19 (a) OCT 2 - 1946 (Date rec'd by registrar) Huntington Pallottine, Md. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1946, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1946 to Oct. 1 1946, and that I last saw h[illegible] alive on Oct. 1 1946.

	Duration
Immediate cause of death (a) Pneumonia, lobar, right lower lobe	less than 1 week
Due to (b) Splenitis, acute	1"
Due to	
Other Conditions Anemia, type undetermined	over

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur M. Monroe
Address Marine Hospital, Date signed 10.1.46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44225 Registered No.

Please write the cause of death clearly and legibly. Cancer is especially important. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 E. Randall St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits write RURAL and give county)
(d) Street No. 609 E. Randall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude M. Bradshaw

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife [redacted]
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9 1863

8. AGE: Years 83 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John W. Garnett
13. Birthplace Virginia

MOTHER 14. Maiden Name Wilhelmina Hacker
15. Birthplace Virginia

16 (a) Informant Robert C. Bradshaw
(b) Address 609 E. Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1426 Light St.

19 OCT 2 - 1946 (Date rec'd by registrar) Curtis Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1946, at 8 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1946 to Oct 1 1946 and that I last saw h[illegible] alive on Oct 1 1946

Immediate cause of death: (a) Cerebral Hemorrhage — Duration 3 mos.
Due to: (b) Arterio Sclerosis — 6 mos.
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Mallette M.D.
Address 1279 Dulaney Pl. Date signed 10/4/46

VS 150

G44226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44226 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Crosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 64 Months Days If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Elizabeth Boston

(b) Address 514 Mayfair Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3. 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bentley ave

19 (a) (Date received by registrar) (b) Huntingtown Md

OCT 2 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1946, at 10 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1946 to 8 - 1946 and that I last saw h Qa alive on Aug 1946

Immediate cause of death: Cerebral hemorrhage.

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris A. Dame M. D.

118 Bisquit St Date signed 9/30/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G44227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 W.Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD R. RICH or Eldridge R. Rich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1894

8. AGE: Years	Months	Days	If less than one day
52	1	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Box man

11. Industry or business American Ice Co.

FATHER 12. Name Danial Rich
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Jones
15. Birthplace Va.

16 (a) Informant Rachel Nutt
(b) Address 1019 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elias A. Wilen
(b) Address 1000 Brantly Ave

19 (a) OCT 2 1946 (Date rec'd by registrar) (b) [illegible] Baltimore, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1946 at 5.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease; Syphilitic aortitis

Acute congestive cardiac failure; Edema and congestion of lungs Edema of brain

DUE TO Moderate advanced generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Thomas J. Mullen, M.D. Medical Examiner.
Date signed 9/30/46

G44228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G44228 Registered No.

Write the causes of death clearly and legibly. Certificate is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 E. Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Maranto

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-7632

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Anna M Cicero

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1883

8. AGE: Years	Months	Days	If less than one day
62	11	9	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Yellow Cab Co

FATHER
12. Name Joseph Maranto
13. Birthplace Italy

MOTHER
14. Maiden Name Frances Cicero
15. Birthplace Italy

16 (a) Informant Miss Frances Maranto
(b) Address 717 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Nita Wiedefeld
(b) Address 900 East Biddle St

19 (a) (b)
Date received by registrar OCT 2 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1946, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1946, to 19
and that I last saw him alive on 9-28 1946

Immediate cause of death	Duration
Carcinomatosis	several month
Due to Hypernephroma, left kidney	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Tillett, Jr. M. D.
Address Johns Hopkins Hospital Date signed 10-2-46

44229 — BALTIMORE CITY HEALTH DEPARTMENT — 44229

CERTIFICATE OF DEATH 95 C

Registered No.

Please write the causes of death clearly and legibly. Physicians: please [illegible] is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA V. SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1861

8. AGE: Years	Months	Days	If less than one day
85	6	28	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John Ehlert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Fuller
15. Birthplace Germany

16 (a) Informant Mrs. Wilhelmina Ittner
(b) Address 903 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Schwartz Cemetery
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1946, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5- 1936 to 10- 1 1946 and that I last saw h alive on 10-1 1946

Immediate cause of death: Acute Myocardial Failure — Duration: 1 day
Due to: Chronic Heart Disease
Due to: Pneumonia
Other Conditions: Influenza

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lourge Lapp M. D.
Address 578 Walnut St. Date signed X 10-1-46

VS 199

G44230

DOA 9/5/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓119a

Registered No. G44230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give County)
(d) Street No. 1226 Argyle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hargrove ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-46

8. AGE: Years | Months | Days: 19 | If less than one day: 3 weeks min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Emma
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 1 1946

18 (a) Funeral director Commissioner of Health
(b) Address
OCT 3 1946 Harold F. Williams MD
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946, at 2 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946 to Sept 27 1946 and that I last saw [illegible] on Sept 27 1946.

Immediate cause of death	Duration
DIARRHOEA OF THE NEWBORN	12 days
Due to	
Due to	
Other Conditions PREMATURITY	LBG.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H Hardy M. D.
Address Johns Hopkins Hosp Date signed 9/28/46

VS 150

X

G44231

B.L. G-7752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

G44231
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Armstead Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Snider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 29, 1946

8. AGE: Years	Months	Days	If less than one day
			2 hr. 22 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Allen Snider
13. Birthplace

MOTHER
14. Maiden Name Lillian Huston
15. Birthplace Ohio

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc. Johns Hopkins Medical School OCT 1 1946

18 (a) Funeral director Commissioner of Health
(b) Address
OCT 3 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1946, at 1:46 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 29 1946 to Sept. 29 1946, and that I last saw him alive on Sept. 29 1946

Immediate cause of death: Erythroblastosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 9-30-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G44232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 174a

G44232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Green
(c) Hospital or institution Md. Un. Hop. 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Glover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Buda - George M. Buda

3 (b) If veteran, name war

3 (c) Social Security Account No. 202-01-2772

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charlotte Buda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23 - 1919

8. AGE: Years 27 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business Glen L. Martin

FATHER
12. Name Michael Buda
13. Birthplace Balto.

MOTHER
14. Maiden Name Mamie Kolnig
15. Birthplace Balto.

16 (a) Informant Mrs. Charlotte Buda
(b) Address 514 N. Glover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 5 46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 3 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-46 19 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23-46 to 10-1-46 and that I last saw him alive on 10-1-46 19

Immediate cause of death: Acute Monocytic Leukemia
Duration
Due to: & spontaneous hemorrhage into vital organs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Bauer M. D.
Address University Hospital Date signed 10-4-46

X

Write the causes of death clearly and legibly.

G44233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G44233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Osmond McCRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annabelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-9-1906

8. AGE: Years 70 Months 1 Days 24 If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Wm. McCray

13. Birthplace S.C.

MOTHER 14. Maiden Name Amanda Johnson

15. Birthplace S. C.

16 (a) Informant Anna Belle McCray

(b) Address 503 N. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem Location Baltimore, Md

18 (a) Funeral director William A. Jackson

(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

OCT 3 - 1946

VS 15d

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1946 at 11 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1946 to 9-30 1946 and that I last saw h. alive on 9-30 1946

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Malignant Hypertension	
Cerebrovascular Accident	
Due to Terminal Uremia	
Cardiac dilitation	
Other Conditions ectopic pregnant	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature University Hospital M. D.
Address Date signed 9-30-46

X

G44234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Rondeau 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA MOSLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Henry C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/1888

8. AGE: Years 58 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Brunswick Co Va (Town, county, and state)

10. Usual Occupation House-maid

11. Industry or business Family

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Dr Price Mosley
(b) Address 1735 McCulloh St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 10-6-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Jno Geo. F. Holland
(b) Address 1631 Druid Hill Ave

19 (a) OCT 3 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/46 19 , at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C Davis M.D. Medical Examiner.
Date signed 10/2/46

VS 191

G44235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 569

G44235 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1879

8. AGE: Years 66 | Months 11 | Days 25 | If less than one day: hr. min.

9. Birthplace Lancaster Co. Va (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER — 12. Name Henry Jones
13. Birthplace Lancaster Co. Va

MOTHER — 14. Maiden Name Minnie Williams
15. Birthplace Lancaster Co. Va

16 (a) Informant Margaret E. Jones
(b) Address 2301 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lyd. H. Stallard
(b) Address 1641 Druid Hill Ave

19 (a) Oct 9 — 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 — 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to Sept. 30 1946, and that I last saw him alive on Sept. 30 1946.

	Duration
Immediate cause of death: Cerebral tumor	about 2 yrs
Due to: —	
Due to: —	over
Other Conditions: —	
(Include pregnancy within 3 months of death)	
Date of operation: —	
Major findings of operation: —	
of autopsy: —	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Seidel, M.D.
Address 2404 Entaw Pl. Date signed 10/2/46

VS 150

G44236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Reg. 6941836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Riggs Av. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-16-1901

8. AGE: Years 44, Months 10, Days 14, If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

PARENTS

12. Name Peter Washington

13. Birthplace D.C.

HUSBAND OR WIFE

14. Maiden Name Fannie Jenkins

15. Birthplace D.C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto Md

18 (a) Funeral director Jno A. Holland

(b) Address 1631 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1946 at 11.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1946, to Sept 30 1946, and that I last saw her alive on Sept 30 1946.

Immediate cause of death: Pulmonary consolidation

Interval between onset and death

Due to: Left-sided empyema, chronic, tuberculous, with bronchial fistula, all part. due to Tuberculosis — Duration: 3-4 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Autopsy (gross pathology)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. D. Davis

Address Johns Hopkins Hospital Date signed 9/30/46

VS 150

Write the causes of death clearly and legibly. Items 1-5 especially important. Physicians: please write

G44237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44237 Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 Andrew St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 d
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Andrew St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Poland

3 (a) FULL NAME Adam Todorski (Fodorsky)

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife MARCYANNA CZERWIAK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/6/1873

8. AGE: Years	Months	Days	If less than one day
72	11	24	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Anna Rykowska
(b) Address 1416 Andrew St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Gorsuch Mill Rd.

18 (a) Funeral director John M. Shelley
(b) Address 401 S. Chester St.

19 (a) (Date rec'd by local registrar) (b) Registrar

OCT 3 - 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1946, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1946 to Sept. 30 1946, and that I last saw h[illegible] alive on Sept. 30 1946.

Immediate cause of death	Duration
Cerebral Edema	7 days
Due to Cerebral Hemorrhage	
Due to Arteriosclerosis	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Lynlevitz M. D.
Address 2116 W. Pratt Date signed 10/1/46

X

G44238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G44238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Fleet Street
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cichocki Or(Chase)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-9063

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of [redacted] wife Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27-1892

8. AGE: Years 54 | Months 1 | Days 5 | If less than one day: hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Revere Copper & Brass Inc.

FATHER
12. Name Frank Cichocki
13. Birthplace Poland

MOTHER
14. Maiden Name Constance Augustyniak
15. Birthplace Poland

16 (a) Informant Stella Cichocki (Wife)
(b) Address 2435 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann Street

19 OCT 3 - 1946 (Date rec'd by registrar)

Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2nd 1946, at 8.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1946, to Oct 2 1946, and that I last saw him alive on Oct 1 1946.

Immediate cause of death Bronchogenic Carcinoma of the Rt Lung. — Duration 3-6-46

Due to

Due to Cancer

Other Conditions None.

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Schumunk M. D.

Address 842 S. Eaton Rd Date signed 10-2-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

G44239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

G44239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mazie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-04

8. AGE: Years 41 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Boat Black

11. Industry or business

FATHER
12. Name Walter Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Blanche Brown
15. Birthplace Md

16 (a) Informant Rosinda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Joseph G. Lock, Jr.
(b) Address 1302 N. Central Ave

19 (a) OCT 3 = 1946 (Registrar's signature) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1946 at 7.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1946, to Sept. 30 1946 and that I last saw him alive on Sept. 30 1946

Immediate cause of death Exhaustion

Due to Exhaustion of mind

Due to Untreated Diabetes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-30-46

Major findings of operation Coma

of autopsy Untreated diabetes.

	Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Donaker M.D.
Address [illegible] Date signed 10/1/46

VS 150

G44240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G44240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Home (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MATILDA GOEBRICHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1865

8. AGE: Years 80 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Portsmouth, Ohio.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Lusaman Goebrichen

13. Birthplace Germany

MOTHER 14. Maiden Name Regina ?

15. Birthplace Germany

16 (a) Informant Miss. Sarah Goebrichen

(b) Address Sinai Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46. (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew

Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son

(b) Address 1902 Eutaw Place

19 (a) (b)

(Date received) Registrar

OCT 5 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1946, to Oct 2 1946, and that I last saw h alive on Oct 2 1946.

Immediate cause of death: Cardio respiratory - Arrest

Due to Pulmonary Embolism

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 23, 1946

Major findings of operations Carcinoma of Sigmoid

of autopsy: Yes

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

D. Signature Allan H. Mark M. D.

Address Sinai Hospital Date signed Oct 3, 1946

X

G44241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G44241 Registered No. 3498

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 N. Mount
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 N. Mount (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-27-1906

8. AGE: Years	Months	Days	If less than one day
40	1	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Brooks
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Coleman
15. Birthplace Md

16 (a) Informant Hilda Mercer
(b) Address 2222 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2/46 (month) (day) (year)
(c) Cemetery or crema... Mt. Auburn Cem
Location

18 (a) Funeral Miles R. Elliott & Daughter
(b) Address 1149 N. Carolina St.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

OCT 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-1946; at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28-1946 to 9-30 1946, and that I last saw him alive on 9-29 1946.

Immediate cause of death	Duration
Myocarditis	unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed Oct 3 1946

X

G44242 ✓ G44242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 Lyndhurst St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE A. ROSS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Turner A. Ross
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1877

8. AGE: Years	Months	Days	If less than one day
69	1	16	hr. min.

9. Birthplace: Howard Co., Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: John J. Fleming
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden Name: Hannah A. Driver
15. Birthplace: Md.

16 (a) Informant: Mr. Walter L. Ross
(b) Address: 7110 Wardman Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46 (month) (day) (year)
(c) Cemetery or crematory: Poplar Springs Cem.
Location: Howard County, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 3 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1st 1946, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Oct. 1st 1946, and that I last saw her alive on Oct. 1, 1946.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 hrs.
Due to (a) Hypertension.	2 yrs.
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas E. Weller M. D.
Address 4100 Edmondson Ave. Date signed 10/1/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44243
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.
(b) Street address 4702 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4702 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony John Hudson

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-03-8915

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Edith M. Hudson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1898

8. AGE: Years	Months	Days	If less than one day
47	9	22	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business A. & P. Stores Co.

FATHER
12. Name John B. Hudson
13. Birthplace R. I.

MOTHER
14. Maiden Name Emma Hummel
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Edith M. Hudson
(b) Address 4702 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 2 - 1946 (Date rec'd by registrar) (b) [illegible] M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1946 at 12:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature A. P. Schrioh M.D.
Medical Examiner.
Date signed 10/2/46

G44244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G44244

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
Us Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oakland Mills Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Giese, Henry Adolph

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	214-01-4858

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Myrtle E. Schorr Giese
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1893

8. AGE: Years	Months	Days	If less than one day
53	5	25	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Machinist (retired)
11. Industry or business U. S. Navy

FATHER
12. Name John H. Giese
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Agnes Sauers
15. Birthplace Har ord Co. Md.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 3 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1946, at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1946 to Oct. 2 1946, and that I last saw him alive on Oct. 2 1946.

	Duration
Immediate cause of death Coronary sclerosis with recent myocardial infarction.	
Due to Nephrosclerosis, with hypertension.	
Due to	
Other Conditions Cardiac hypertrophy.	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon, U.S.P.H.S.
Official Title of Certifier
Address U.S. Marine Hospital, Baltimore 11, Md. Date signed 10/2/46

G44245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G44245 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 E. 33rd. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 E. 33rd. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE LILLIAN LEARY

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John T. Leary
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1892

8. AGE: Years 54 | Months 7 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Percy Keeting
13. Birthplace Virginia

MOTHER
14. Maiden Name Lena Lindung
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. John T. Leary
(b) Address 1727 E. 33rd. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) (b) Thurlington Williams, M.D. Registrar

OCT 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1946, at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to Oct 1 1946, and that I last saw him alive on Oct 1 1946.

Immediate cause of death — Duration

Valvular Heart disease — 2 Mos
Due to
Due to
Other Conditions Diabetes Mellitus — 5 yrs.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Frahm M. D.
Address 1623 N. Wash. St. Date signed 10/2/46

92 D

G44246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

✓ G44246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St. Joseph's Hospital 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Bayonne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Barbara Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W

6 (a) Single, married, ~~widowed~~ or divorced Widowed

6 (b) Name of husband or wife William J. Stein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/77

8. AGE: Years 69 Months 7 Days 13 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER: 12. Name Peter Dedis; 13. Birthplace Germany

MOTHER: 14. Maiden Name Frances Hegert; 15. Birthplace Germany

16 (a) Informant Miss Frances Stein

(b) Address 3008 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-46 (month) (day) (year)

(c) Cemetery or crematory Parkwood Location Baltimore

18 (a) Funeral director Leonard J. Rusk

(b) Address 5805 Harford Rd.

19 (a) 10-3-1946 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2/46 19 at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1946 to 10/2 1946 and that I last saw h alive on 10/2 1946

Immediate cause of death: Cardiac Failure — Duration

Due to: Uremia — Duration

Due to: Pyelonephritis — Duration

Other Conditions: Arteriosclerosis — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Brielle M. D.

Address St Jos Hosp Date signed 10-3-46

VS 150

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

G44247 Dowell G44247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6012 Bertram Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6012 Bertram Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George F. Dowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Marion M-
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21-1856

8. AGE: Years	Months	Days	If less than one day
90	8	11	hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Benjamin Dowell
13. Birthplace Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant Mrs. Mary Adams
(b) Address 6012 Bertram Ave.

17 (a) Burial (b) Date thereof 10-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto.

18 (a) Funeral director Leonard J. Ruck.
(b) Address 5305 Harford Rd.

19 (a) OCT 3 - 1945 (b) Huddleston Williams, M. D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2 1946 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 10-2 1946 and that I last saw him alive on 9-30 1946.

Immediate cause of death
Hernia — Duration 2 days
Due to Chronic Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 10-3-46

VS 3

G44248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G44248
Registered No.

Write the causes of death clearly and legibly. Physicians please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Steelton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Steelton Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW B. FOGLEMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6 1895

8. AGE: Years	Months	Days	If less than one day
51	6	25	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Carroll L Fogleman
(b) Address 1128 Steelton Ave.

17 (a) Burial (b) Date thereof 10 4 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Aye
18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.
19 (a) OCT 3 PM 10 (b) Huntington Williams, M.D.
(Died not by registrant)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1946 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Oct 1 1946, and that I last saw h[illegible] alive on Oct 1 1946.

Immediate cause of death
Hypertensive C-V-R
Disease

	Duration
Due to	Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Dundalk-22 Md Date signed 10-7-46

VS 150

G44249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G44249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Bank St (If rural, give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country Naturalized

3 (a) FULL NAME Joseph Korycki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Caroline Korycki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1883

8. AGE: Years	Months	Days	If less than one day
63	8	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Michael Korycki
13. Birthplace Poland.

MOTHER
14. Maiden Name Agnes Barnas
15. Birthplace Poland

16 (a) Informant Mrs. Caroline Korycki
(b) Address 1918 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd

18 (a) Funeral director Lilly & Jenkins
(b) Address 403 S. Holly St.

19 (a) (Date received by Registrar) (b) Registrar

OCT 8 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1946, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1946 to Oct. 1 1946 and that I last saw him alive on Oct 1, 1946.

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Lobar pneumonia & septicemia	5 days
Due to	
Other Conditions Aplastic Anemia	1 year

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

73. Signature Howard [illegible]
Address Mercy Hosp. Date signed 10/7/46

G44250 BCH B56875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44250 Registered No. 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore General
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 E Lorraine St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Bacon.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 9/12/1946
8. AGE: Years 0 **Months** 0 **Days** 20 **If less than one day** X X X min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph a Bacon.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Agnes I Dukes.
15. Birthplace Baltimore Md

16 (a) Informant Joseph a Bacon.
(b) Address 943 Lorraine St
17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/3/46 (Month) (Day) (Year)
(c) Cemetery or crematory Jew Cathedral
Location Frederick Rd. Baltimore Md
18 (a) Funeral director George J. Ruth Inc.
(b) Address 1725 Hilford Ave.
19 (a) (Date registered) **(b)** (Registrar)
OCT 3 - 1946 Lester Williams, M.D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 19 46 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 19 46 to 10/2 19 46 and that I last saw h[illegible] alive on 10/2 19 46.

Immediate cause of death Volvulus of small intestine & perforation.
Due to Peritonitis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E L Barrows.
Address **Date signed** 10/3/46

X

AB-104589 G44251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No. G44251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Francis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13-[illegible]-1908

8. AGE: Years	Months	Days	If less than one day
-38- 37	10	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Milford Hodges
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Huber
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2806 Jefferson St.

19 (a) (Date rec'd by registrar) Registrar

OCT 3 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2- 1946, at 12.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1946 to 10-2 1946, and that I last saw her alive on 10-2- 1946

Immediate cause of death — Duration

Typic hepatitis
Lobular bronchopneumonia
Due to Chronic alcoholism.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:
Enlarged fatty liver

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dayle Vallon M. D.
Address P. C. 14 Date signed 10/2/46

X

G44252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1469

G44252 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5402 Springlake Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5402 Springlake Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton Fremont Schmidt Jr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 192-03-2746
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lotta E. Schmidt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 10, 1882
8. AGE: Years 63 Months 10 Days 22 If less than one day hr. min.
9. Birthplace Lawrenceville Pa (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business Crown Cork & Seal Corp

FATHER
12. Name Clifton F. Schmidt, Sr.
13. Birthplace Lukeyours

MOTHER
14. Maiden Name Martha Chamberlin
15. Birthplace Lukeyours

16 (a) Informant Robert N. Schmidt
(b) Address 5402 Springlake Way
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md
18 (a) Funeral director Durward L. Covington
(b) Address 21 W. 25th St
19 (a) Huntington Williams M.D. (Date received) (Registrar) Registrar

OCT 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946 11.40 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1937 to Oct 2 1946 and that I last saw living alive on Oct 2 1946.
Immediate cause of death: Carcinoma of Pancreas — Duration between onset and death
Due to
Due to
Other Conditions General metastasis
(Include pregnancy within 3 months of death)
Date of operation Oct. 9 1945
Major findings of operation: Carcinoma of pancreas (inoperable)
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jno A Custer M.D.
Address 122 Rogers St Date signed Oct 3/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44253
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Turners Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. Turners Station
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislaus Hamienck.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 3 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1946 at 8:?? P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sabinske M.D.
Medical Examiner.
Date signed 9/24/46

G44254 BC# 657081 BALTIMORE CITY HEALTH DEPARTMENT G44254
CERTIFICATE OF DEATH V159
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Sharon Ann Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-46

8. AGE: Years | Months | Days 13 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Earl Young
13. Birthplace Md

MOTHER 14. Maiden Name Frances Miller
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) Oct 3 1946 Registrar
(b) Huntington Ave., Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1946, at 2.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1946 to Oct 2 1946 and that I last saw him alive on Oct 2 1946.

Immediate cause of death: DIARRHOEA OF THE NEWBORN — Duration: 1 week
Due to
Due to
Other Conditions PREMATURITY — 4 DS
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Waldy M. D.
Address Johns Hopkins Hosp. Date signed 10-3-46

VS 150

1192

G44255 ROUILLER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G44255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Strieker St.
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 N. Rogers Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen C. Rouiller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles August Rouiller

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug 13 - 1888

8. AGE: Years	Months	Days	If less than one day
58	1	19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Alphonso Noel
13. Birthplace France

MOTHER
14. Maiden Name Anna Finke
15. Birthplace Germany

16 (a) Informant Charles August Rouiller
(b) Address 4103 N. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4-46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Harry N. Armacost
(b) Address 4204 Ridgewood Ave.

19 OCT 1 - 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1946 at 8 45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis
Myocardial infarction.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 10/2/46

VS 151

G44256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6014 Sefton Avenue
(c) Hospital or institution: 27-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 St. George's Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa May Clark

3 (b) If colored, name war ********** | 3 (c) Social Security Account No. **********

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm. Eugene
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1877

8. AGE: Years	Months	Days	If less than one day
68	11	4	hr. min.

9. Birthplace St. Albans, Vermont (Town, county, and state)
10. Usual Occupation At. Home
11. Industry or business

MOTHER / FATHER
12. Name Edgar O. Howard
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace Vt

16 (a) Informant Howard Clark
(b) Address 3101 Ravenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director L. Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) OCT 4 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 October 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Oct. 1946, and that I last saw her alive on 3 Oct. 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Hypertensive Cardiovascular Disease	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo M Zimmerman M.D.
Address 2858 Hanford Rd Date signed Oct. 4/46

G44257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44257 Registered No.

Please write the cause of death clearly and legibly. Consult a Physician if necessary. Physicians: Please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4222 Oakford Ave.
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4222 Oakford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC NOVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Late Hannah
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Kaiba Novey
13. Birthplace Russia

MOTHER
14. Maiden Name Shifra ?
15. Birthplace Russia

16 (a) Informant John Novey
(b) Address 4222 Oakford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3/46 (month) (day) (year)
(c) Cemetery or crematory Shaarei Zion Cem.
Location Hamilton Ave. Rosedale
18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. North Ave.
19 (a) OCT 4 - 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1946 at 1130 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 1937 to 10-3-1946
and that I last saw him alive on Sept 1944

Immediate cause of death: Chronic myocarditis
Due to: Hypertension
Due to: Coronary Sclerosis
Other Conditions:

Duration
5 yrs.
2 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. A. Michelson M. D.
Address 10-4-46 Date signed

VS 150 Huntington Williams, M.D. 2230 Eulan Pl. X

G44258 BALTIMORE CITY HEALTH DEPARTMENT G44258

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mourment & Broadway
(c) Hospital or institution: Sinai Hospital 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Norfolk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA LUTZKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	22	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Moses Chain Levin
13. Birthplace Lith

MOTHER
14. Maiden Name Rose ?
15. Birthplace Lith.

16 (a) Informant Mrs. Rose L. Beser
(b) Address 2503 Queen Ann Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. North Ave.

19 (a) OCT 4 — 1946 (Date filed by Registrar) Registrar for Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1946 at 11 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1946 to Oct 3 1946, and that I last saw h[illegible] alive on Oct 3 1946

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic cardiovascular disease

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 10-3-46

VS 150

X

G44259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G44259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Callow Ave
(c) Hospital or institution: 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Klaff Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Klaff
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Sara Miller
(b) Address 2108 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-46 (month) (day) (year)

(c) Cemetery or crematory Woodsdale Mill Rd
Location Woodsdale Mill Rd

18 (a) Funeral director Jack Reinz Inc
(b) Address 1469 E Balto St

19 (a) (Date received by registrar) (b) OCT 4 1946 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1946 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Oct 3, 1946, and that I last saw h[illegible] alive on Oct 3, 1946

Immediate cause of death: Myocardial Insufficiency — Duration: 1 day
Due to: Arteriosclerosis
Due to: Hypertension
Other Conditions

(Include pregnancy within 3 months of death.)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney D. Frey
Address 2322 Eastern Pkwy Date signed 10/3/46

G44260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44260 Registered No.

Type or use ink. State the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 S. Green
(c) Hospital or institution: 27-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 S Green (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Taylor

3 (b) If veteran, name war S-A-W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Ala (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER 12. Name Thomas Taylor
13. Birthplace Ala

MOTHER 14. Maiden Name Sarah Jenifer
15. Birthplace Ala

16 (a) Informant Ella Cleveland
(b) Address 811 Green St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaac L Brown Sr
(b) Address 1924 Montgomery St

19 (a) (b) Registrar

OCT 4 1946 Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1946 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Oct 2 1946, and that I last saw him alive on Sept 30 1946.

Immediate cause of death	Duration
Chronic Cardio-Hypertensive Disease	Unknown
Due to	
Due to	
Other Conditions Senile Changes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Gaines, M.D.
Address 502 W. Hamburg St Date signed 10/3/46

G44261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44261 Registered No.

Please write the causes of death clearly and legibly. Physician: please sign on reverse side.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Fayette St
(c) Hospital or institution: Bon Secours 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3216 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Goldberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elsie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1886

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocery
11. Industry or business

FATHER 12. Name Abraham
13. Birthplace Russia

MOTHER 14. Maiden Name Hoffee
15. Birthplace Russia

16 (a) Informant Elsie Goldberg
(b) Address 3216 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd. Hamilton Town

18 (a) Funeral director Jack Levin Inc
(b) Address 1409 E Baltimore St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 4 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1946 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1946 to 10-4 1946 and that I last saw him alive on 10-4 1946.

Immediate cause of death	Uremia	Duration
Due to	HCVD.	
Due to	Arteriosclerosis	
Other Conditions	Cerebral Hem.	
	Embolism	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Yearsley M.D.
Address Bon Secours Hosp. Date signed 10-5-46

X

G44262 BALTIMORE CITY HEALTH DEPARTMENT G44262

CERTIFICATE OF DEATH ✓ 94a

Registered No.

1. PLACE OF DEATH: 164
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Quigley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/18/76

8. AGE: Years 70 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Buffalo, N.Y. (Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business Consolidated Eng. Co.

FATHER
12. Name James Quigley
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Walker
15. Birthplace Unknown

16 (a) Informant S. Sylvester
(b) Address 620 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.R. Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) OCT 4 - 1946 (date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11/46 to 10/1/46, and that I last saw h[illegible] alive on Oct 1 1946

Immediate cause of death: Cardiac Failure — Duration

Due to Ant. Coronary A. Occlusion

Due to Generalized Arteriosclerosis

Other Conditions Pericarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Fibrinous and descending branch of anterior of left Coronary

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wells M.D.
Address 18 Jos Hosp Date signed 10-3-46

VS 150

G44263 BALTIMORE CITY HEALTH DEPARTMENT G44263
CERTIFICATE OF DEATH 94a Registered No.

Type or use ink. Fill all items. Underline the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH: 19-2
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution: Aged Womens + Aged Mens Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore Bender

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1856

8. AGE: Years 90 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace Boston, Mass. (Town, county, and state)

10. Usual Occupation Invalid

11. Industry or business Home for Aged

FATHER
12. Name Gustavus W. Bender
13. Birthplace Unknown

MOTHER
14. Maiden Name Fredrica Worple
15. Birthplace Unknown

16 (a) Informant Aged Womens + Aged Mens Home
(b) Address 1400 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Wm. Cook Jno.
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by registrar OCT 4 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1946, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5/1939 19 to 10/2/1946, and that I last saw h. in alive on ? date 19.

Immediate cause of death: Coronary occlusion. — Duration: Sudden.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos B. Jarrell M. D.
Address 11 E. Chase St. Date signed

VS 150

City-2. X 10/3/46

G44264

JL - 104310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G44264

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 263
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Kenyon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John J. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1896

8. AGE: Years	Months	Days	If less than one day
50	0	29	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business —

FATHER
12. Name William Preaty
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Ann Preaty
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Wm Cook Inc.
(b) Address 127 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 4 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1946 at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 19 46 to Oct. 3 19 46. and that I last saw h alive on Oct. 3, 1946

Immediate cause of death: Cirrhosis of liver, alcoholic — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dayl Walker M. D.
Address B.C.H. Date signed 10/3/46

(over)

G44265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710

G44265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Gold Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/1937

8. AGE: Years 9 | Months 7 | Days 13 | If less than one day: hr. min.

9. Birthplace Balto Md. (town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Chas. Davis

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Grace Hopewell

15. Birthplace Balto. Md

16 (a) Informant Mrs. Davis

(b) Address 566 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Geo. H. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) OCT 4 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1946, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull, Laceration of brain, Laceration of abdomen with evisceration, Ruptured spleen.

Due to

Other Conditions Fract. back, pelvis, ribs, jaw bones, nose, and breast bone, and shoulder girdle. (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 1413

(a) Date of injury 10-2-46 at 5:20 P.M.

(b) Where did injury occur? Robert St. & Druid Hill Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Wagon & Streetcar Collision

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 10-3-46

X

G44266

AB-104242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G44266 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Braddish Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Byrne

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1906

8. AGE: Years	Months	Days	If less than one day
40	7	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business —

FATHER
12. Name Edward Byrne
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Tagor or Page
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Ft. Lincoln
Location 130 Woodland Ave.

18 (a) Funeral director John J. Conaty
(b) Address 941-03 Gallows St.

19 Filed OCT 1 - 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1946, at 3.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1946 to 10-3 1946, and that I last saw him alive on 10-3 1946.

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration 3 Days

Due to

Due to

Other Conditions: Laryngeal Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Huntington Williams, Registrar

Address Balt. City Hosp. Date signed Oct. 3 1946

VS 150

G44267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44267 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Granada Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Columbus Eader COLUMBUS CHARLES EADER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Effie D. Eader

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1869

8. AGE: Years 76 Months 11 Days 5 If less than one day hr. min.

9. Birthplace Balto. Md. Md. (Town, county, and state)

10. Usual Occupation odd jobs Carpenter

11. Industry or business

FATHER
12. Name John Eader
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Warfield
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Florence E. Stidman
(b) Address 3808 Granada Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams MD

OCT 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1946 to 10-3 1946 and that I last saw him alive on 10-2 1946

Immediate cause of death: Cardiac Failure — Duration

Due to: Hypertension Cardio-Vascular disease.

Due to:

Other Conditions: Atonic Bladder, Urinary retention; kidney damage.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A Vaughn Jr. M. D.
Address Univ. Hospital. Date signed 10-3-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G44268

Please write the causes of death clearly and legibly. Physicians: please write the specially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 Aiken St.
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Aiken St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM JUERSS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Carolina M. Juerss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1855

8. AGE: Years	Months	Days	If less than one day
91	0	17	hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Francica Vonessen
15. Birthplace Unknown

16 (a) Informant William A. Juerss
(b) Address 2204 Aiken St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery Baltimore
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pennsylvania Ave. Balto. Md.

19 (a) OCT 4 1946 (Date rec'd by registrar) (b) Registrar

Huntington for Wm. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1946, at 7.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct 2 1946, and that I last saw h/m alive on Oct 2 1946.

Immediate cause of death
ARTERIOSCLEROSIS. — Duration 15 YRS

Due to CHRONIC INT. NEPH — 5 YRS

Due to

Other Conditions ANGINA — 2 YRS.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F Kavanagh MD
Address 3218 McKeldin Ave Date signed Oct 4-46

X

G44269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

G44269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 E. Monument St.
(c) Hospital or institution: — 10-2 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County None
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Webb Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Elizabeth Marie Massal

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Joseph A. Massal
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 1. 1891

8. AGE: Years	Months	Days	If less than one day
55	0	2	— hr. — min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business None

FATHER
12. Name Anthony J. Jaeckel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothea M. Bosse
15. Birthplace Baltimore

16 (a) Informant Mrs. Dorothy Cameron
(b) Address 3122 Odell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director J. J. Tolley Sons
(b) Address 1701 Light St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 4 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 October 1946, at 0045 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Sept 1946, to 27 Sept 1946, and that I last saw her alive on 27 Sept 1946.

Immediate cause of death	Duration
Carcinomatosis, general	2 years
Due to Adeno carcinoma Left Breast	2½ years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations —
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Osborne
Address 5302 Harford Rd Date signed 3 Oct 1946

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44270 BALTIMORE CITY HEALTH DEPARTMENT G44270

CERTIFICATE OF DEATH 1937

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution: 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Springfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amalia Fauth

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22-1865

8. AGE: Years	Months	Days	If less than one day
81	7 8	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Dont. Know
13. Birthplace "

MOTHER
14. Maiden Name Dont. Know
15. Birthplace "

16 (a) Informant Mrs Ottenritter
(b) Address 710 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C Yorgan
(b) Address 3600 Baltimore St

19 (a) Filed Oct 4 1946 Registrar, Md. Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 2 1946, and that I last saw h[illegible] alive on Oct 2 1946

Immediate cause of death	Duration
General Arteriosclerosis	10 yrs
Chronic Myocarditis	10 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon
Address 139 S Broadway Date signed Oct 3rd 1946

VS 150

G44271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44271
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-2
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 669 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Okie Jackson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Furniture Store

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Carrie Jackson
(b) Address 725 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Aden Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 4 - 1946 (Date rec'd by registrar) (b) Huntingtor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29- 1946, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Per William G. Helfrich, M.D. Medical Examiner. M.D.
Date signed 10-2-46

VS 191

G44272 BALTIMORE CITY HEALTH DEPARTMENT G44272
CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1201
(b) Street address
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Pennsylvania Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Richmond Virginia
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Lucas Brothers

FATHER
12. Name Lee Carter
13. Birthplace Virginia

MOTHER
14. Maiden Name Maria ?
15. Birthplace Virginia

16 (a) Informant Thomas Dabney
(b) Address 521 N. Biddle St.

17 (a) Burial (b) Date thereof Oct 1 1946
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 1 1946 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis, Miliary

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 9-28-46

G44273 Over BALTIMORE CITY HEALTH DEPARTMENT G44273
CERTIFICATE OF DEATH 159 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH: 26-4
(a) Baltimore City, Maryland
(b) Street address 3636 E. Fayette St.
(c) Hospital or institution: Bay View Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3636 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RAYMOND MICHALSKI

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1 day
8. AGE: Years — Months — Days 1 If less than one day 20 hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Raymond Michalski
13. Birthplace Md.
MOTHER 14. Maiden Name Antionette Wysocki
15. Birthplace Md.
16 (a) Informant
(b) Address
17 (a) 10-5-46 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Rosary. Location Leonard Hall Jct. Elkridge Landing Rd.
18 (a) Funeral director Williams & Bowden
(b) Address 1618 Eastern Ave.
19 (a) (Date received by Registrar) 1946 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct. 3 1946, at 7:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1946 to Oct. 3 1946 and that I last saw him alive on Oct. 3 1946.
Immediate cause of death Asphyxiation Duration
Due to Asphyxiation
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James E. Ware M. D.
Address Bay View Hosp. Date signed 10-7-46

VS 180

AB-104928 G44274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G44274

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Arundel Hotel-1320 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES ARTHUR MERCERET

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4- 1903

8. AGE: Years	Months	Days	If less than one day
43	3	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Frank Mercerat
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Benzinger
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director H. K. Mears and Son
(b) Address 805 N. Calvert St.

19 OCT 4 - 1946 (Date received by registrar) Thurlington Williams Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH October 3- 1946, at 3.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30- 1946, to 10-3 1946, and that I last saw him alive on 10-3 1946.

Immediate cause of death: Pulmonary Tuberculosis, Bilateral, Far advanced — Duration 19 yrs.
Due to
Due to
Other Conditions: Hydrothorax, Rt. Empyema, Rt. Pneumothorax, Rt.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William J. Hunt
Address Balt. City Hosp. Date signed Oct. 3 1946

VS 190

275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-4 D.04
(b) Street address
(c) Hospital or institution: Mercy Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Tucker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Coroner
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 4 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1946 at 6.40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis
Due to
Other Conditions Arteriosclerotic
CV disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. R. Lauben M.D.
Medical Examiner.
Date signed 9/28/46

4276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G44276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 W. Fayette Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. HALL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state) Unknown
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 4 1946 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1946, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, ~~Inspection or Inquiry~~ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic rheumatic heart disease with mitral and aortic
Due to stenosis

Other Conditions Coronary arteriosclerosis
Scoliosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/16/46

G44277. BALTIMORE CITY HEALTH DEPARTMENT X ✓ G44277.

CERTIFICATE OF DEATH 1946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 7 20
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Magnolia (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William D. Demby

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-6760

4. Sex: Male | 5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gladys Demby

6 (c) If alive, give age ? ? years

7. Birth date of deceased (mo., day, yr.) May 26, 1923

8. AGE: Years 23 | Months 4 | Days 9 | If less than one day: hr. min.

9. Birthplace Magnolia, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Demby
13. Birthplace Maryland

MOTHER
14. Maiden Name Jennie Turner
15. Birthplace Maryland

16 (a) Informant Mrs. Jennie Demby
(b) Address Magnolia Harford Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-46 (month) (day) (year)

(c) Cemetery or crematory Location Magnolia, Harford Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle Street

19 OCT 4 - 1946 (Date rec'd by Registrar) (b) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1946, at 12 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1946 to Oct. 4 1946, and that I last saw him alive on Oct. 4 1946.

Immediate cause of death: Dislocation of 6th cervical vertebra — Duration

Due to: Execution by hanging

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Anderson, M.D.
Address Maryland Penitentiary Date signed 10-4-46

X

G44278 Koesters

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D ✓

G44278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Orleans St.
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Orleans St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Koesters

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-1926

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary J. Signataro

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Aug. 26-1880

8. AGE: Years 66 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Brass Molder

11. Industry or business Brass Foundry

FATHER 12. Name William Koesters
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Peters
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Mary J. Koesters
(b) Address 2802 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Elizabeth Hartz Funeral Home
(b) Address 143 S. Paca St. Williams, Mgr.

19 (a) Filed OCT 4 - 1946 (b) — Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2/46 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1-46 19 Oct 2/46 19 and that I last saw him alive on Oct 1-46 19

Immediate cause of death: Acute Edema Lungs.
Due to Chronic Endocarditis
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

36 yrs
17+

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen C. Hauck M.D.
Address 1429 W. Mulberry Act. 4/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G44279 BC# 500589. #85171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G44279 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 23-3
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Marshall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie Elizabeth Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-43

8. AGE: Years	Months	Days	If less than one day
3	0	21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edgar Jones.
13. Birthplace Md.

MOTHER 14. Maiden Name Lillian Rowery
15. Birthplace Md

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Wm Cook Inc.
(b) Address Baltimore, Md (Funeral for Middleburg, Md)

19 (a) Date rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1946 at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1946 to Oct 3 1946. and that I last saw her alive on Oct. 3 1946.

Immediate cause of death: Tuberculous meningitis — Duration

Due to: Miliary tuberculosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Greenhood M. D.
Address Johns Hopkins Hospital Date signed 10-4-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G44280
Registered No.

please write the causes of death clearly and legibly. Physicians: please be especially important. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Holbrook Street
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine J. Brady

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Charles A. Brady
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1864

8. AGE: Years	Months	Days	If less than one day
82	8	8	hr. min.

9. Birthplace New Jersey
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry VanDyke
13. Birthplace New Jersey

MOTHER
14. Maiden Name Unknown Johns
15. Birthplace New Jersey

16 (a) Informant Maude Fischer
(b) Address 1508 Holbrook Street

17 (a) burial (b) Date thereof 10/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 OCT 4 - 1946 (b) Huntington Ave
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1946, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to Oct 3 1941 and that I last saw him alive on Oct 3 1946

Immediate cause of death: Uremia - Convulsions — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singh M. D.
Address 506 E Monument Date signed 10-4-46

X

G44284 P.L.J-58633 BALTIMORE CITY HEALTH DEPARTMENT ✓ G44281
CERTIFICATE OF DEATH 159
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Colvin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gore

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 25-1946

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Liston Gore
13. Birthplace S.C.

MOTHER
14. Maiden Name Lela or Leola Bellany
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-1-46 (month) (day) (year)
(c) Cemetery or crematory Balto. City Hosp.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

OCT 4 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29- 1946, at 7.10AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1946 to 9-29 1946, and that I last saw her alive on 9-29-46 1946.

Immediate cause of death: Bronchopneumonia — Duration

Due to Aspiration

Due to Prematurity

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address City Hospital Date signed 30 Sept

VS 150

G44282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44282 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 N Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John O'Neill

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1866

8. AGE: Years 79 78 | Months 11 | Days 20 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Owen J Neill
13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Byrnes
15. Birthplace Ireland

16 (a) Informant Mrs J J Mack
(b) Address 2731 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)

(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director Patty Sons
(b) Address 31 W Lafayette St.

OCT 4 - 1946 Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1946, at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1946, to 10-3 1946, and that I last saw him alive on 10-3 1946.

Immediate cause of death: Cardio-respiratory failure — Duration
Due to Congestive heart failure
Due to Anterior coronary heart disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E Mary M.D.
Address Calvert & Saratoga Sts. Signed 10-3-46

X

44283 Golley

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G44283 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Frankford Avenue
(c) Hospital or institution: 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Frankford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes E. Eckhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Alvin Eckhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1884

8. AGE: Years	Months	Days	If less than one day
61 59	9 10	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Michael Suchbradl
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Alvin Eckhardt
(b) Address 2910 Frankford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 10-8-1946 (Date rec'd by registrar) (b) Huntington for Williams Mt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946 at 3.2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to 10/4 1946 and that I last saw h[illegible] alive on 10/4 1946.

Immediate cause of death Hypertension Cardio Vascular Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury KYLE W. GOLLEY

23. Signature Kyle W. Golley M.D.
Address 5305 Harford Rd Date signed 10/5/46

VS 150

G44284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G44284

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmont Ave.
(c) Hospital or institution: Margaret Carpenter Home Inc
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Lyndale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna S. Schwartz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Albert J. Schwartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9th 1883

8. AGE: Years 62 | Months 9 | Days 23 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER: 12. Name Richard L. Mills
13. Birthplace Md.

MOTHER: 14. Maiden Name Amanda Stier
15. Birthplace Md.

16 (a) Informant Robt. A. Schwartz
(b) Address 3504 Lyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

OCT 4 - 1946 Huntington Williams, MD
(Date rec'd) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2nd 1946, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1946 to Oct 2 1946 and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days

Due to: Arteriosclerotic

Due to: Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. O. Stevens M.D.
Address 3402 Eastern Ave. Date signed 10/4/46

G44285 Approved

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G44285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Eichberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Wh

6 (a) Single, married, widowed, or divorced Mar

6 (b) Name of husband or wife Bertha Eichberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1897

8. AGE: Years 48 Months 9 Days 6 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Max Eichberg
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Mayer
15. Birthplace Germany

16 (a) Informant (Son) Danny Eichberg
(b) Address 1807 Ruxton Ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Funeral Home
(b) Address 1902 Eutaw Pl. Balto, Md.

19 OCT 5 - 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1946, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946, to 19 , and that I last saw him alive on Oct 4 1946

Immediate cause of death: Pulmonary edema — Duration

Due to Myocardial failure

Due to Coronary occlusion (old)

Other Conditions ISCVD

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Henry G. Slaughenhaupt M. D.

Address U. M. H. Date signed 10/5/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

D. H. Harris, Jr. Howard A. Harris, M.D.

G44286

BALTIMORE CITY HEALTH DEPARTMENT

TH- 100446

CERTIFICATE OF DEATH 186a

Registered No. G44286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months & 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Fitzpatrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1855 ? 1855

8. AGE: Years 90 | Months ? 11 | Days ? 4 | If less than one day hr. min.

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret McDeveitt
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Transit (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Phila, Penna

18 (a) Funeral director L. J. Rusk
(b) Address 530 Hanford St.
(c) Huntington Williams, Md.

OCT 5 - 1946
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4/1946 19 at 10.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7th 1946 to Oct 4/ 1946 and that I last saw her alive on Oct. 4/ 1946

Immediate cause of death: Arteriosclerotic Cardio-vascular Disease — Duration: months

Due to: Bronchopneumonia Bilateral — days

Due to: Fracture, Intertrochanteric Rt. Femur — 6 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence about 4-6-46 at M
(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell down stairs

23. Signature Charles Mitchell M. D.

Address Balt. City Hosp. Date signed 10-4-46

VS 190

Approval of Medical Examiner Howard J. Knudsen, M. D. X

Write the causes of death clearly and legibly. Physicians: please write the correct age in specially important.

44287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G44287 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 Orleans St
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Krug

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-8005

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Eleanor Krug
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) July 21-1903

8. AGE: Years	Months	Days	If less than one day
43	2	22	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation General
11. Industry or business Continental Can Co

FATHER
12. Name John Krug
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Dittmer
15. Birthplace Balto

16 (a) Informant Eleanor Krug
(b) Address 2324 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Ulrich Funeral
(b) Address 2006 Orleans St

19 (a) OCT 5 - 1946 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3/46 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2nd yr 10/2 1946, to 11th yr 10/3 1946 and that I last saw h alive on 10/3 1946.

Immediate cause of death Cerebral hemorrhage (Pontine)

Due to Hypertension and Cardio Renal Disease (3)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pontine hemorrhage.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature Jerry Porter M. D.
Address Sinai Hospital Date signed 10/4/46

VS 150

G44288 — BALTIMORE CITY HEALTH DEPARTMENT — G44288

CERTIFICATE OF DEATH 93

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 S Bouldin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 S Bouldin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm F. Critzman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annah Critzman
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 2/18/1866

8. AGE: Years	Months	Days	If less than one day
80	7	16	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business 16 Yrs

FATHER
12. Name Otto Critzman
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Anna L. Critzman
(b) Address 604 S Bouldin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7th (month) (day) (year)
(c) Cemetery or crematory 5th Reformed
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) OCT 5 - 1946 (Date received by local registrar) (b) Huntington Williams, M.D. Address 2559 Eastern Date signed 10/4/46

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1946 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1-1938 19 to Oct. 4 1946 and that I last saw him alive on Oct 2 1946.

Immediate cause of death
Hypertension Cardio Vascular Disease
Hypertensive Encephalopathy

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Landon Williams M.D.
Address 2559 Eastern Date signed 10/4/46

VS 150

X

G44289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G44289

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3524 E. Baltimore St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estelle L. Schlieder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Jewell W. Schlieder
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 11, 1885

8. AGE: Years	Months	Days	If less than one day
61	0	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name August H. Rullman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Fannie Colley
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Nellie Pauls
(b) Address 3524 E. Baltimore St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7/46 (month) (day) (year)
(c) Cemetery or crematory Oak Farm
Location Balto Md

18 (a) Funeral director Ulbert Funeral Home
(b) Address 2008 Orleans St

19 Date received by registrar OCT 5 - 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1946, at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946 to Oct 3 1946 and that I last saw h[er] alive on Oct 3 1946.

Immediate cause of death	Duration
(a) carcinomatosis	7 mos.
Due to (b) carcinoma of ileum	1 yr.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L C Dobihal
Address 447 N. Kenwood Ave. Date signed 10/4/46 M. D.

L C, Dobihal

G44290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G44290

~~B-104011~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 4
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 W. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ollie Bourne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife LeRoy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 26, 1[illegible]

8. AGE: Years	Months	Days	If less than one day
42	9	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Isaac Buck
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte?
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-6-46
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Lusby-Calvert Co. Md.

18 (a) Funeral director Chas. H. Cooper
(b) Address 570-572 Cantelon Ave.

OCT 5 - 1946
(Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH October 1 1946, at 10.20

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1946, to 10-1 1946, and that I last saw h 9r alive on 10-1 1946.

Immediate cause of death Circulatory Failure — Duration

Due to Stroke

Due to Diabetes Mellitus & Coma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. L. Lattimore M. D.
Address Balto. City Hosp Date signed 10-2-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G44291 Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age if especially important

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1951 N. Collington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2

(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1951 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Piraino

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband late Emanuele Piraino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 30 1872

8. AGE: Years	Months	Days	If less than one day
73	10	4	hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Giuseppe Messina
13. Birthplace Italy

MOTHER
14. Maiden Name Santa BARRANCO
15. Birthplace Italy

16 (a) Informant Vincent Pisaino (Son)
(b) Address 2602 E.Monument St.

17 (a) Burial (b) Date thereof Oct.7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18. (a) Funeral director Frank Della Rocca
(b) Address 52 N.Morley St.

19. Date rec'd by OCT 5 - 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1946, at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1946 to 10/4 1946 and that I last saw h.e.r. alive on 10/3 1946.

Immediate cause of death Coronary Failure — Duration

Due to Senility

Due to Arterio Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Frank Della Rocca

Address 1128 St. Paul St. Date signed 10/5/46.

VS 150

G44292 BC# D57032 BALTIMORE CITY HEALTH DEPARTMENT X 159 Registered No. G44292

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turner Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Flicker Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Donald Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 20, 1946

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Coleman Davis
13. Birthplace South Carolina

MOTHER
14. Maiden Name Ruth Watkins
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave, Huntington Williams, Md

19 (a) OCT 5 - 1946 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1946, at 11:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1946 to Oct 3 1946, and that I last saw h im alive on Oct. 3 1946.

Immediate cause of death Prematurity — Duration
Thrush
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 10-3-46

Please write the causes of death clearly and legibly. Physicians: please note that correct age is especially important.

VS 150

G44293 BCH 95703 C

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 159

Registered No. G44293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turner Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Flicker Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 20, 1946

8. AGE: Years | Months | Days: 12 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Coleman Davis
13. Birthplace South Carolina

MOTHER
14. Maiden Name Ruth Watkins
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy E. Wilson
(b) Address 1000 Brant St

19 (a) OCT 5 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1946, at 5:12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1946 to Oct. 2 1946, and that I last saw him alive on Oct 2 1946.

Immediate cause of death Prematurity — Duration
Thrush
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address Johns Hopkins Hospital Date signed 10-2-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G44294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G44294

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elnora Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1897

8. AGE: Years	Months	Days	If less than one day
79	5	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Abraham Banks
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Virginia Dorlock
15. Birthplace Balto Md.

16 (a) Informant Evelyn Cook
(b) Address 927 Rutland Ave.

17 (a) Burial (b) Date thereof Oct 5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County Md

18 (a) Funeral director Mrs. Cliff O. Ellsworth
(b) Address 1129 N. Carrollton Ave

19 [illegible] (Date paid by undertaker) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946, at 7 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9, 1946, to 10/2, 1946, and that I last saw h[illegible] alive on 9/30 1946

Immediate cause of death	Duration
Mitral insufficiency	UNK
Due to	
Due to	
Other Conditions Hypertensive cardio-renal disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at , M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne X

Address 1500 E. Madison St. Date signed 10/4/46

VS 130

RAYNER BROWNE X

G44295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G44295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3126 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JULIA LOUISE EVERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Melvin E. Everson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1878

8. AGE: Years	Months	Days	If less than one day
68	0	4	hr. min.

9. Birthplace Wisconsin (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Fay
13. Birthplace Wisconsin

MOTHER
14. Maiden Name - Pertsch
15. Birthplace Unknown

16 (a) Informant Mrs. Lawrence G. Baker
(b) Address 3126 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Local Registrar OCT 5 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1946 at 9:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1946 to 10-3 1946 and that I last saw h alive on 10-3 1946

Immediate cause of death Hypernephroma - R. Kidney — Duration 2 yrs ?
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Ashman M. D.
Address 201 Pigtail Annex Date signed 10-9-46

VS 150

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44296 BC# B56889 BALTIMORE CITY HEALTH DEPARTMENT G44296
CERTIFICATE OF DEATH 160a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA HICKMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8-46

8. AGE: Years | Months: 3 WKS | Days: 26 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Hickman
13. Birthplace Md.

MOTHER 14. Maiden Name Jennie Myers
15. Birthplace md

16 (a) Informant Mrs Joseph Hickman
(b) Address 2009 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7th 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) OCT 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946, at 11.20 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage (subdural)
spontaneous
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mahoney M.D.
Medical Examiner.
Date signed 10/4/46

VS 151

G44297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G44297

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write carefully important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 795 George St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 795 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Draper.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Draper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 24, 1874

8. AGE: Years 72 | Months 7 | Days 8 | If less than one day: hr. min.

9. Birthplace Kent County, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Betty Mason.
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Harriett Chambers.
15. Birthplace Kent. Co. Md.

16 (a) Informant Mrs. Corrine Hall.
(b) Address 795 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 1946 (Month) (day) (year)
(c) Cemetery or crematory Georgetown Md
Location Kent Co. Md.

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St

OCT 5 - 1946 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Oct 2 1946 and that I last saw her alive on Oct 2 1946

Immediate cause of death: Cerebral Hemorrhage

Due to: Hypertensive Cardio-Vascular Renal Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Powell M. D.

Address 1001 N Carrollton Ave Date signed 10/5/46

VS 150

G44298 BC 9-60427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G44298 Registered No.

Please write the cause of death clearly and legibly. Physicians: please see that the entries are especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Mimosa St.
(c) Hospital or institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Baby of Thelma Hicks) James Hicks.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	negro	Single

6 (b) Name of husband or wife Infant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-46.

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Hicks.
13. Birthplace

MOTHER
14. Maiden Name Thelma Easter
15. Birthplace Va.

16 (a) Informant Thelma Hicks.
(b) Address 317 Carrollton Ave.

17 (a) Burial (b) Date thereof Oct 2 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 5 1946 (b) Huntington Williams M.D.
(Date received by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 2 - 1946, at 9 a.m. p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1946, to 10-2 1946, and that I last saw him alive on 10-2 1946

Immediate cause of death	Duration
Atelactasis	2 dy
Due to	
Due to Prematurity	32 Weeks
Other Conditions Maternal Eclampsia (Include pregnancy within 3 months of death)	10 hrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. Louis Jones M. D.
Address 1120 Eutaw Pl. Date signed 10/2/46

X

B. C. D. Accordion Register

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 112

Registered No. G44293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 N. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Drake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1921

8. AGE: Years 25 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas W Drake
13. Birthplace Va

MOTHER
14. Maiden Name Eva N Davis
15. Birthplace Va

16 (a) Informant Mary Tinson Sister
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5th 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location U. A. Co. Md.

18 (a) Funeral director Bryant Morris & H. Haig
(b) Address 724 Augusta St

19 (Date rec'd by registrar) OCT 3 1946 Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2, 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from DOA 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Asthma (acute) — Duration 7 yrs.

Due to Acute Bronchial Asthma

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund L. Dubois M. D.
Address Johns Hopkins Hospital Date signed Oct 3

VS 150 Form 5 Revised 1946

To be accepted by Medical Examiner

Corner right is especially important. Physicians: please write the causes of death clearly and legibly.

G44300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G44300

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 E. 30th, St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Ba ltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 E. 30th, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick A. Senger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ora E. Whaland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1887

8. AGE: Years	Months	Days	If less than one day
59	3	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name George J. Senger
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericks A. Unerzacht
15. Birthplace Germany

16 (a) Informant: Mrs Ora W. Senger
(b) Address 1723 E. 30th, S t

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5,46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemty
Location East North Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Date filed (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3, 1946, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1940 to Oct 3 1946 and that I last saw him alive on Oct 1 1946

Immediate cause of death

Thrombosis of Coronary artery — Duration 1 hour

Due to

Due to

Other Conditions Hypertension. Cerebral Atherosclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vernon H. Hopwood
Address Church Home & Hospital Date signed Oct 5 1946

G44301

501320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G44301

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Waco. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 N. 26th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Mickl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-41

8. AGE: Years	Months	Days	If less than one day
5	5	15	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Julius ?
13. Birthplace Texas

MOTHER
14. Maiden Name Anna Maria Torch
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Waco, Texas

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1900 Enterprise Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 5 1946

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct - 4 1946 at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct - 3 1946 to Oct - 4 1946 and that I last saw him alive on Oct - 4 1946

Immediate cause of death	Duration
Cerebral thrombosis and cardiac arrest.	acute
Due to Blalock Operation	1 d.
Due to for Pulmonary Stenosis	5 yr.
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation 10-4-46
Major findings of operation: Pulmonary Stenosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. B. Monaco M. D.
Address JHH Date signed 10-5-46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C44302 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. C44302

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address R. Calvert St.
(c) Hospital or institution: Mercy Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
Costa Rica
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mercy Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Syrette

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1946

8. AGE: Years	Months	Days	If less than one day
		2	45 hr. 10 min.

9. Birthplace Baltimore Maryland.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Syrette
13. Birthplace Costa Rica

MOTHER 14. Maiden Name Virginia Davidson
15. Birthplace Baltimore

16 (a) Informant Mercy Hosp Records
(b) Address R. Calvert St.

17 (a) Burial (b) Date thereof 10/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Catholic

18 (a) Funeral director J. F. Stephens
(b) Address 318 Light St.

19 OCT 5 - 1946
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 PM Oct 3 1946 to 12 AM Oct 4 1946.
and that I last saw him alive on Oct 4, 1946.

	Duration
Immediate cause of death: respiratory failure	45 m
Due to: pulmonary congestion	10 min.
Due to: atelectasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Garlach M. D.
Address Mercy Hospital Date signed 10-7-46

44303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44303

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Kirkwood & Gilmor Sts.
(c) Hospital or institution: West Hosp 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Nova
(c) City or town Baltimore-9.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 South Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Culotta (or) Frank F. Culotta

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 25 1875

8. AGE: Years	Months	Days	If less than one day
71	4	8	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Culotta
13. Birthplace Italy

MOTHER
14. Maiden Name Frances Costi
15. Birthplace Italy

16 (a) Informant Josephine Culotta
(b) Address 2200 South Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. V. E. Oppel's Sons
(b) Address Lombard & Bond Sts

19 (a) Filed by registrar OCT 5 - 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1946; at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1946 to 10-3 1946, and that I last saw h[illegible] alive on 10-3 1946.

Immediate cause of death	Duration
Pulmonary edema & anasarca	
Due to Cardiac failure	
Due to Arterio sclerotic Hypertensive cardio vasc. disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. K. Durigg M. D.
Address Home Hosp Date signed 10-3-46

VS 150

G44304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 198

Registered No. G44304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 7 20
(e) Length of stay in Baltimore (yrs., mos., or days) ??

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Magnolia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roy N. Peters

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1923

8. AGE: Years 23 | Months 0 | Days 18 | If less than one day: hr. min.

9. Birthplace Magnolia, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Theodore Peters
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Hannah Gilbert
15. Birthplace Maryland

16 (a) Informant Miss F. Williams
(b) Address Magnolia Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/46 (month) (day) (year)
(c) Cemetery Magnolia cemetery
Location Magnolia, Maryland.

18 (a) Funeral director A. Hatfield
(b) Address 918 Druid Hill Ave.

19 (a) OCT 5 - 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1946 at 12:31 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1946, to Oct. 4 1946, and that I last saw him alive on Oct. 4, 1946

Immediate cause of death	Duration
Dislocation of 5th cervical vertebra	
Due to Execution by hanging	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Anderson M. D.
Address Maryland Penitentiary Date signed 10-4-46

X

G44305 Ostmann

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 170 c

Registered No. G44305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George Co.
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 Talbott Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Bernard Ostmann

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Charlotte Ostmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1921

8. AGE: Years	Months	Days	If less than one day
24 25	10		hr. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: Navy Dept.

FATHER
12. Name: Anton Ostmann
13. Birthplace: Wash. D. C.

MOTHER
14. Maiden Name: Mary C. Howard
15. Birthplace: Wash. D. C.

16 (a) Informant: Frank M. Howard
(b) Address: 617 Jefferson St., N.W. Wash. D.C.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 10/5/46 (month) (day) (year)
(c) Cemetery or crematory: Arlington National
Location: WASHINGTON, D.C.

18 (a) Funeral director: FRANK GEIER'S Sons Co.
(b) Address: Washington, D.C.

19 (a) OCT 5 - 1946 (Date rec'd by Registrar) (b) Hunter-Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1946, at 10 35 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 10-4-46 at 9 30 P. M.
(b) Where did injury occur? Nr. on Wash. Blvd., 1 mi. NW. of Laurel, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Pedestrian struck by auto

23. Signature Howard J. Theodosis M.D.
Medical Examiner.
Date signed 10-5-46

VS 19t Information furnished by Funeral Director.

G44306 G44306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & St. Johns St.
(c) Hospital or institution:
Womens Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3239 Magnolia Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Iona Ganoe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White.	Married.

6 (b) Name of husband or wife Charles E. Ganoe
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 8/18/1882

8. AGE: Years	Months	Days	If less than one day
64.	1	18	hr. min.

9. Birthplace Berkley Springs, W. Va.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

MOTHER / FATHER
12. Name George Householder.
13. Birthplace Berkley Springs W. Va.
14. Maiden Name Mary Covermale
15. Birthplace Berkley Springs W. Va.

16 (a) Informant Iona Ganoe
(b) Address 3239 Magnolia Ave.

17 (a) Removal (b) Date thereof Oct. 6, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Berkley Springs, W. Va.

18 (a) Funeral director W. H. S. Tichner & Sons
(b) Address North & Pa. Aves.

19 (a) Date rec'd by Registrar Oct 7 1946 (b) Filed by Registrar Oct 8 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/46 19 , at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27/46 19 , to 10/5/46 19 , and that I last saw her alive on 10/5/46 19 .

Immediate cause of death Cardiac insufficiency, Failure
Due to Surgical Shock.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 10/5/46.
Major findings of operation: Gallbladder removed at time of operation.
of autopsy.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. D. Wolfe M. D.
Address Lafayette & Johns St. Date signed 10/5/46

37616 G44307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44307 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Carolina County
(c) City or town Lumberton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Iva Sue Spell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-37

8. AGE: Years 7 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thurman Spell
13. Birthplace Mississippi

MOTHER
14. Maiden Name Martha Bergman
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Fairfield Md.

18 (a) Funeral director Geo. C. Moran
(b) Address 3810 Wilkens Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1946, at 10 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1946, to 10-8 1946, and that I last saw h[illegible] alive on 10-8 1946.

Immediate cause of death Respiratory failure

Due to Operation

Due to Tetralogy of Fallot

Other Conditions

Duration

(Include pregnancy within 3 months of death)

Date of operation 10/3/46

Major findings of operation: Tetralogy of Fallot. Single subpulmonary obstruction. Aortic Arch Right

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Johns Hopkins Hospital
Address Henry J. Bahnson Date signed 10/13/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44308
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Southern
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rout ~~#~~ 1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilkerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Married

6 (b) Name of husband or wife ~~Living or dead~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-24-04

8. AGE: Years	Months	Days	If less than one day
42	8 7	9 11	hr. min.

9. Birthplace Oxford, N.C.
(Town, county, and state)
10. Usual Occupation Baggage man
11. Industry or business N & W. R.R. Co.

FATHER
12. Name William Wilkerson Sr.
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace N.C.

16 (a) Informant William Wilkerson Jr.
(b) Address Southern, Va. Route #1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Hagle
Location Southern, Virginia

18 (a) Funeral director Charles R. Lawson
(b) Address 802 Madison Ave.

19 (a) 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5th 1946 to Oct. 5th 1946 and that I last saw him alive on Oct 5th 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Day
Due to Hypertensive Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wallace M. D.
Address 801 Madison Date signed

Huntington Williams, M.D.

X

G44309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44309 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Greenway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Greenway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Foster Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife N. Winslow Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1865

8. AGE: Years 80 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Hartford Conn
(town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Frederick Rose Foster
13. Birthplace Conn.

MOTHER
14. Maiden Name Harriet Smith
15. Birthplace Conn.

16 (a) Informant F. Fostey Williams
(b) Address 4112 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry McCulloch Hopkins Bros Co
(b) Address McCulloch Richard Sts

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1946 to Oct 5 1946, and that I last saw h[illegible] alive on Oct 4 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Arterio-Sclerosis

Incident to Advanced Age

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Dreyer M.D.
Address 1115 St Paul St Date signed Oct 5

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Baltzer 1101 St Paul

G44310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G44310 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3603 Rosedale Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Rosedale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella V. Geiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband George H. Geiger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23rd 1859

8. AGE: Years	Months	Days	If less than one day
86	11	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name George L. Hamel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Alice K. Hurlock
(b) Address 3603 Rosedale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) 10/7/46 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1946, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945 to Oct. 4, 1946, and that I last saw h alive on Oct. 4, 19

Immediate cause of death: Bronchopneumonia — Duration: 1 day

Due to

Due to

Other Conditions Carcinoma of Leg
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hildegarde L. Levy, M.D.
Address 1515 Eutaw Place Date signed 10/5/46

VS 180

P.L. B-5 1946
G44311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G44311
Registered No.

1157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore + Fayette Sts
(c) Hospital or institution:
Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Elvaton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Nursing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1946

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore 23 Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Chester C. Nursing
13. Birthplace Md.

MOTHER
14. Maiden Name Marguerite S. Stewart
15. Birthplace Md.

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof Oct. 7th 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dell.
(b) Address 1501 E. Fort Ave

19 (a) [illegible] Williams, M.D. Registrar

10-7-1946

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1946, at 6:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1946, to Oct. 5 1946, and that I last saw him alive on Oct. 5 1946.

Immediate cause of death	Duration
Heart failure	
Due to Congenital heart defect	5 days
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan Dixon

Address 819 Med Arts Bldg Date signed 10-7-46

X

Write the cause of death clearly and legibly. Physicians: please write the cause of age is especially important.

G44312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G44312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35-E. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles F. McLAUGHLIN

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Georgia C. Harrison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd 1905

8. AGE: Years	Months	Days	If less than one day
41	3	1	hr. min.

9. Birthplace Harrisonburg Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Pennsylvania R. R.

FATHER
12. Name Frank McLaughlin
13. Birthplace Va.

MOTHER
14. Maiden Name Effie Goodman
15. Birthplace Va.

16 (a) Informant Mrs Georgia C. McLaughlin
(b) Address 35 E Schroeder St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Washington Blvd. Dorsey Md.

18 (a) Funeral director Jno. J. Cowan & Son
(b) Address 1303 Hollins St.

19 (a) 1946 (Date rec'd by registrar) (b) Hunter's Town Williams, M.D. Registrar

V8 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1946, at 11 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic and subacute bacterial endocarditis of aortic valve with aortic valvular stenosis, and hypertrophy and karring of left ventricle of heart.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. G. Merrill M.D. Medical Examiner.
Date signed 10/7/46

G44313 BALTIMORE CITY HEALTH DEPARTMENT G44313

CERTIFICATE OF DEATH 43a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S.Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1184 Cleveland Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Spillman, William Brewster

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marguerite Feller
6 (c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) August 28, 1890
8. AGE: Years 56 | Months 1 | Days 7 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Restaurant Keeper
11. Industry or business Restaurant

FATHER
12. Name George Spillman
13. Birthplace Md.

MOTHER
14. Maiden Name Kate Norton
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 3934 Frederick Ave
18 (a) Funeral director John J Gowan & Son
(b) Address 401-03 E Fallows St.
19 (a) OCT 6 - 1946 (Date rec'd by local reg.) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 19 46, 2:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 29 46 to October 5, 46 and that I last saw h im alive on Oct. 5 19 46

Immediate cause of death: Cerebral hemorrhage. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L Wilson
John L. Wilson, Sr. Surgeon, M. D.
Address Clinical Director Date signed 10/5/46
U.S.Marine Hospital, Balto.Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44314

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D-S-A
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Baldwin

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1886

8. AGE: Years	Months	Days	If less than one day
60	5	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business Unknown

FATHER
12. Name Unknown.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Hazel Linthicum
(b) Address 2226 Booth St

17 (a) Burial Medical (b) Date thereof 10/7/36
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2939 Frederick Ave

18 (a) Funeral director John Conquest Son
(b) Address 901-03 Baltimore St

19 (a) 10/5/36 Huntington Williams, M.D.
(Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1936, at 2 00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h·2 death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Pinkham M.D.
Medical Examiner.
Date signed 10/4/36

VS 181

X

G44315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

G44315 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 John St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L. Baldwin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Charles G. Baldwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1869

8. AGE: Years	Months	Days	If less than one day
76	10		hr. min.

9. Birthplace Brooklyn, N. Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frederick Moss
13. Birthplace England

MOTHER
14. Maiden Name Adelaide Hohorst
15. Birthplace

16 (a) Informant Mr. John A. Baldwin
(b) Address 1302 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Baldwin Mem. Cemy.
Location Severn Cross Rds. A.A.Co. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

6 — 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1946 to Oct. 4, 1946 and that I last saw her alive on Sept. 27 1946

Immediate cause of death Cerebral thrombosis — Duration 24 hrs.

Due to Arteriosclerosis — Many years

Due to

Other Conditions Diabetes mellitus — 6-8 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard M.D.
Address 17 E. Eager St. Date signed Oct. 6, 46

83B

G44316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44316 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave
(c) Hospital or institution:
Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bibi Sapoor Sechrist

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Wd

6 (b) Name of husband or wife, George H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1865 D.L.

8. AGE: Years 80 | Months 10 | Days 23 | If less than one day 22 hr. min.

9. Birthplace Stanbroad Pa
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Simon Keil

13. Birthplace Unknown

MOTHER 14. Maiden Name Elizabeth Batzner

15. Birthplace Germany Pa.

16 (a) Informant Alberta Nursing Home

(b) Address 4013 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-46 (month) (day) (year)

(c) Cemetery or crematory Lutheran Cem.

Location Shrewsberry, Pa.

18 (a) Funeral director Joseph Eyrs

(b) Address 5605 Reisterstown Rd

19 (a) 10-7-1946 (Date rec'd by registrar) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5th 1946, at 12:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1946, to Oct 5 1946, and that I last saw h.e alive on Oct 3rd 1946.

Immediate cause of death Heart Failure — Duration 12 hrs

Due to Myocarditis — 6 mos

Due to Arteriosclerosis — 1 year

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature J.E. Coulton

Address 3909 Reisterstown Rd Date signed 10/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G44317 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga & Parkland
(c) Hospital or institution: Mt. Bethesda Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 Denmore Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard C. Filbert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Married

6 (b) Name of husband or wife Mae F. Filbert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr. 13, 1886

8. AGE: Years	Months	Days	If less than one day
60.	5	23	hr. min.

9. Birthplace Baltimore, Md
(town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Paper (Newsprint)

FATHER
12. Name William Filbert
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ina Wagner
15. Birthplace Balto. Md

16 (a) Informant Mrs. Alexander
(b) Address Cayuga & Parkland
17 (a) Burial (b) Date thereof 10-8-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director Long & Byers
(b) Address 5005 Park Heights Ave
19 (a) Filed by Registrar Huntington Williams M.D. Registrar
(b) Date filed OCT 6 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 19 46 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 19 46 to Oct 6 19 46
and that I last saw h. alive on Oct 6 19 46

Immediate cause of death	Duration
Respiratory Failure	
Due to Pul. Edema.	
Due to Cerebral Incoordination	
Other Conditions Hypertension Prostatectomy Hypertrophy, Senile	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard C. Hall M. D.
Address 5005 Park Heights Ave Date signed Oct 6 1946

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44318 Registered No. 94a

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 S. Charles St
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Carney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Rena Carney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/1866 1886

8. AGE: Years	Months	Days	If less than one day
60	7	18	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick Carney
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Flatery
15. Birthplace Ireland

16 (a) Informant Mrs Rudolph Lloyd
(b) Address 1520 S Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Hitchie Highway

18 (a) Funeral director John J. Kirby & Sons
(b) Address 1318 Light St
19 (a) [illegible] (b) Date rec'd by reg. Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1946 at 5 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1946 to Oct 3 1946 and that I last saw h[illegible] alive on Oct 2 1946

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Senile Arteriosclerosis & nor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. T. Hawkins M. D.
Address 1 E Randall St Date signed

VS 150

G44319 — BALTIMORE CITY HEALTH DEPARTMENT — G44312

CERTIFICATE OF DEATH 150

Registered No.

Please write the causes of death clearly and legibly. Report age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Cummings St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Cummings St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lenora Tyler

3 (b) If veteran, name war —
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Divorced
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 1, 1894

8. AGE: Years	Months	Days	If less than one day
52	7	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation machine worker
11. Industry or business

FATHER
12. Name William Stanley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lillie Stanley
15. Birthplace Balto. Md.

16 (a) Informant: William Stanley
(b) Address 1714 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Thos. S. Hanlon
(b) Address 1691 Druid Hill Ave.

19 (a) (Inspector) (b) Date rec'd (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1946 to Oct 3 1946 and that I last saw alive on Oct 3 1946.

Immediate cause of death	Duration
Hemorrhage of bread	2yrs
Due to Infection	
Due to —	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos. S. Hanlon M. D.
Address 1202 Druid Hill Ave Date signed 10-5-46

VS 150

G44320 G44320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 N. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Archie S.
6 (c) If alive, give age , years

7. Birth date of deceased (mo., day, yr.) 2/28/1862.

8. AGE: Years	Months	Days	If less than one day
84	7	6	hr. min.

9. Birthplace Harford County
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Richard S. Wheeler
13. Birthplace Harford County Md.

MOTHER
14. Maiden Name Frances E. Rider
15. Birthplace Harford County Md.

16 (a) Informant Sylvan E. Price
(b) Address 114 N. Payson St.

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof 7 Oct. 46
(month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Sykesville, Md.

18 (a) Funeral director C. F. Bellefant & Son
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1946 to 10/4 1946, and that I last saw h[illegible] alive on 10/4 1946

Immediate cause of death	Duration
Arteriosclerotic Cardio-Renal	
Vascular Disease	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature Dr. Edgar Loughlin
Address 40 N. Payson St. Date signed 10/5/46 M. D.

VS 480 Huntington Williams M.D.

OCT 6 - 1946

X

G44321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G44321 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Thomas S. Wills. "Thomas G. Wills"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Married

6 (b) Name of husband or wife Mamie D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/1859

8. AGE: Years	Months	Days	If less than one day
87	7	8	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Retired - Conductor
11. Industry or business Penna R.R.

FATHER
12. Name John Frederick Wills
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Mary Dibbin
15. Birthplace Maryland

16 (a) Informant Mrs. Mamie D. Wills
(b) Address 426 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director C. D. Whitpain & Son
(b) Address 700 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1946, at 8 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 3 1946, and that I last saw him alive on Oct 3 1946

Immediate cause of death:
Carcinoma of the Oesophagus.
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Gannon
Address St Agnes Hosp Date signed Oct 3 46

400181 G44322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E G44322 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Calif. (b) County
(c) City or town Montebello, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Easton, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gurva Sue Matlock

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-42

8. AGE: Years	Months	Days	If less than one day
4	—	5	hr. min.

9. Birthplace Calif. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Gurvis Matlock
13. Birthplace La.

MOTHER
14. Maiden Name Mary Doom
15. Birthplace Texas

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12-46 (month) (day) (year)
(c) Cemetery or crematory Location Montebello Calif
1946
16 (a) Funeral director Ellsworth Arrasmith
(b) Address 3911 Liberty Heights
19 (a) Thurston Williams, M.D. (by) Dve
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 25

20. DATE OF DEATH Oct - 6 - 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Cerebral Thrombosis — Duration 31

Due to Operation for

Due to Pulmonary Stenosis — Life

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10-1-46
Major findings of operation: Pulmonary Stenosis
of autopsy: "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. B. Morrow M. D.
Address 1111 Date signed 10-6-46

VS 155 U

G44323 — BALTIMORE CITY HEALTH DEPARTMENT — G44323 Registered No.

CERTIFICATE OF DEATH A2B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luke Petera
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-11-02
8. AGE: Years 43 Months 8 Days 25 If less than one day hr. min.
9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Sa. State Claim Agent
11. Industry or business
FATHER 12. Name John J. Petera
13. Birthplace Pa
MOTHER 14. Maiden Name Mary Greco
15. Birthplace Pa
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery Location Wilkinsburg Pa
18 (a) Funeral director Oden Funeral Service
(b) 4644 York Road
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1946 at 10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1946 to Oct 6 1946 and that I last saw him alive on Oct 6 1946
Immediate cause of death Circulatory Collapse — Duration
Due to Multiple emboli, vegetations
Due to Subacute Bact. Endocarditis, Acute Chronic Rheumatic Heart Disease
Other Conditions Mitral Stenosis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. M. Knight M. D.
Address Date signed

VS 150

Huntington Williams, M.D.

Congestive age is especially important. Physicians: please write the causes of death clearly and legibly.

4324 P.C.H.-# 58506 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G44324

CERTIFICATE OF DEATH 158

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw & Mulberry Aves
(c) Hospital or institution Saint Agnesses Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore -14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 5403 Tramore Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby boy Lipscomb

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles R.
13. Birthplace Md

MOTHER
14. Maiden Name Helmerhring Reynolds
15. Birthplace Md

16 (a) Informant Father.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 7 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1946. 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1946 to 10/2 1946 and that I last saw h.[illegible] alive on 10/2 1946.

Immediate cause of death	Duration
Cardiac & circulatory collapse.	2 hours
Due to Lack of development (2 weeks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elizth. Mortimer Hall M. D.
Address 2708 St Paul St. Date signed 10/5/46

VS 190

G44325 Fetal Register J-58126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 161a

G44325 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmont Ave
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (21)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Brienwood Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Linde.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Caucasian	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1946

8. AGE: Years	Months	Days	If less than one day
		1/2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation New Born.

11. Industry or business

FATHER — 12. Name William Oscar Linde

13. Birthplace

MOTHER — 14. Maiden Name Mildred Mary

15. Birthplace

16 (a) Informant Mildred Mary Linde

(b) Address above

17 (a) Burial (b) Date thereof 10 7 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. C. Gartner

(b) Address Gaithersburg, Md.

(Date rec'd by) OCT 7 - 1946 (b) Huntington Williams, M.D. (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1946, to Oct 5 1946 and that I last saw h[illegible] alive on Oct 5 1946.

Immediate cause of death	Duration
Atelectasis	
small placental infa	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Mullica M. D.

Address 6 East Eager St Date signed

X

Dr. Golley
5703 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G44326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pineridge Nursing Home
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Evergreen Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. James

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced
female	white	Widowed.

6 (b) Name of husband or wife Herschel J. James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1860

8. AGE: Years	Months	Days	If less than one day
86	6	1	hr. min.

9. Birthplace Ebensburg, Pa.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER | PARENTS
12. Name Thomas Jones
13. Birthplace Wales

MOTHER | PARENTS
14. Maiden Name Martha Williams
15. Birthplace Pa.

16 (a) Informant Mrs. Mary J. Weatherwax
(b) Address 932 North 65th St. Phila.

17 (a) Burial (b) Date thereof 10/ /46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kane Cemetery
Location Kane, Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

OCT 7 - 1946
(Date received by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1946, to 10/6 1946, and that I last saw h[illegible] alive on 10/6 1946.

Immediate cause of death: Hypostatic Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kyle M. Golley M.D.
Address 5703 Harford Rd. Date signed 10/7/46

Washington Hollinsworth Registrar

Please write the causes of death clearly and legibly. Physicians please write in ink. Correct age is especially important.

14327 BC# F 48257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157a

Registered No. G14327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 Ashland Ave.
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS D. HUNT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 42

8. AGE: Years	Months	Days	If less than one day
4	5	12 11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Hunt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marie Holub
15. Birthplace Baltimore

16 (a) Informant Charles Hunt
(b) Address 2018 Ashland Ave.,

17 (a) Burial (b) Date thereof 10-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Frank Cvach & Son
(b) Address 900 N. Chester St.

19 (a) (Date received) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946, at 10.15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Hydrocephalus

Due to

Other Conditions Healed Trephine wound of skull
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haggerty M.D.
Medical Examiner.
Date signed 10-8-46

BL-D-58575
G44328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1600

G44328 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland –
(b) Street address Maternity Hospital
(c) Hospital or institution: Redwood & Green Sts

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days) 10 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Extended
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Maternity Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Pittman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4-46

8. AGE: Years	Months	Days	If less than one day
10 min	—	—	— hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Harry Pittman
13. Birthplace Newport News, Va

MOTHER
14. Maiden Name Bessie Hicks
15. Birthplace Portsmouth, Va.

16 (a) Informant Bessie Pittman
(b) Address 634 Green St

17 (a) Burial (b) Date thereof 10-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Leonard L Dorsey
(b) Address 1824 W Mondawmin Ave

19 (a) (b)
(Date rec'd by registrar)

OCT. 7 – 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1946, at 3 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 4 1946 and that I last saw h her alive on Oct 4 1946

Immediate cause of death Cardiac Respiratory Failure — Duration

Due to Intracranial Hemorrhage

Due to Prolonged Labor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Clarence W Martin
Address Univ. Hosp Date signed Oct 4 46 M. D.

X

4329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Daniels (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Alberton Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Maccca Campbell

13. Birthplace Howard Co Md

14. Maiden Name Margaret Rogers

15. Birthplace Balto Co

16 (a) Informant Robert L. Campbell

(b) Address 2430 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7-1946 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location West Port

18 (a) Funeral director Va Brooks

(b) Address 1463 N. Carey St

(a) Date received by registrar OCT 7 - 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1946, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Oct. 3 1946, and that I last saw h[illegible] alive on Oct 3, 1946.

Immediate cause of death: Congestive Heart Failure — Duration

Due to Arteriosclerotic Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles L Wallace M. D.

Address 861 Hanlon St Date signed 10-5-46

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G44330
TN. 103331

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1313

Registered No. G44330

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months & 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 626 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Crook

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mattie P. Crook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st.1885

8. AGE: Years	Months	Days	If less than one day
61	1	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Checker
11. Industry or business Motion Picture Business

FATHER
12. Name Edward J. Crook
13. Birthplace England

MOTHER
14. Maiden Name Catherine Campbell
15. Birthplace Garrett County Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Registrar OCT 7 1946 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5th 1946, at 4.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1946 to Oct 5 1946 and that I last saw him alive on Oct 5th 1946

Immediate cause of death Pulmonary Tuberculosis, Far. advanced — Duration 3yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 10-5-46

X

G44331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G44331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Lymbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Lymbrook Ave (If rural give location)
(e) Citizen of foreign country? Lymbrook (Yes or No)
If yes, name country

3 (a) FULL NAME Ida E. TRUITT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife W. Frank Truitt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 8, 1878

8. AGE: Years	Months	Days	If less than one day
68	8	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Fowler
13. Birthplace Md.

MOTHER
14. Maiden Name Emma DeFord
15. Birthplace Kent Co., Md.

16 (a) Informant Mr. Weldon Truitt
(b) Address 2514 Calverton Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Chester Cem.
Location Chestertown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 7 — 1946 (Date Rec'd by Registrar) (b) Huntington W. Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1946, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular-renal disease.

Lacerations of scalp and face

Due to Fracture of nose.

Other Conditions

(Include pregnancy within 3 months of death)

Injuries did not even contribute to death.

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-4-46 at 9 P. M.
(b) Where did injury occur? 2202 Lymbrook Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Pt. struck and fell down stairs to basement

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 10/5/46

G44332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G44332 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 S. Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTANAS NEMURA NAMURS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
93			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Vincent P. Nemura
(b) Address 610 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Rd

18 (a) Funeral director Joseph Kasmikas
(b) Address 607 Washington Blvd

19 (a) (Date rec'd by registrar) (b) Washington William Burial Permit

OCT 7 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Monday 1946 to Oct 5 1946 and that I last saw h. alive on Oct 5 1946.

Immediate cause of death	Duration
Cerebral Thrombosis	1 day
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions Carcinoma of Respiratory System (Bronchus) (Include pregnancy within 3 months of death)	1 yr.

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature John P. Uelock Jr M.D.
Address 122 W Wash. Blvd Date signed Oct 6 1946

G44333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G44333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 N. Calvert St D.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mark Ulman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-3884

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Nellie L. Ulman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1881

8. AGE: Years	Months	Days	If less than one day
64	10	29	hr. min.

9. Birthplace Salisbury, Md.
(Town, county, and state)
10. Usual Occupation Liquor Salesman
11. Industry or business

FATHER
12. Name Simon Ulman
13. Birthplace Ohio

MOTHER
14. Maiden Name Caroline Long
15. Birthplace Pa.

16 (a) Informant Mrs. Nellie L. Ulman
(b) Address 3401 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Louis Sonneborn & Sons
(b) Address 1902 Eitaw Place, Baltimore, Md.

19 (a) Date received by registrar 1946 Awaiting for Filing
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1946, at 12:30 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Arteriosclerotic C-V disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 10/5/46

VS 181

G44334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G44334

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4217 Chatham Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Chatham Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin E. Dannenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband/wife Wilhelmina D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1890

8. AGE: Years	Months	Days	If less than one day
56	5	6	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Clerk - Food Fair

11. Industry or business

FATHER
12. Name Herman Dannenberg
13. Birthplace Germany

MOTHER
14. Maiden name Ernestine Schmiefeld
15. Birthplace Germany.

16 (a) Informant Mrs. M. E. Dannenberg
(b) Address 4217 Chatham Rd.

17 (a) Burial (b) Date thereof 10/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harid Sonnenstein & Son
(b) Address 1902 Eutaw Place

19 (a) 10/5/46 Huntington Hollins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1946 to Oct 6 1946 and that I last saw him alive on Oct 6 1946.

Immediate cause of death	Duration
Carcinoma of Liver & Intest. Obstr.	2 mos.
Due to Carcinoma of Sigmoid	2 1/2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 4, 1946

Major findings of operation: Carcinoma of Liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Samuel J. Hamburger M.D.

Address 7031 Eutaw St Date signed 10/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44335 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Annadale Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Berliner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1882

8. AGE: Years 64 | Months 1 | Days 17 | If less than one day: hr. min.

9. Birthplace Lynchburg, Va.
(Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Emanuel Berliner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Herrman
15. Birthplace Germany

16 (a) Informant Mrs. C. Winternitz
(b) Address Annadale Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friends Assn.
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS J50

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1946 at 10 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1946 to Oct 6 1946 and that I last saw h[illegible] alive on Oct 6 1946

Immediate cause of death: Coronary Occlusion — Duration: 12 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

25. Signature: Samuel D. Daly, M.D.
Address Sinai Hospital Date signed 10/8/46

G44336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G44336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Oswego Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Levine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1898

8. AGE: Years	Months	Days	If less than one day
48	6	16	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Green Spring Dairy

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs Al Caplan
(b) Address 3732 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mide Rd.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1104-26th North Ave.

19 (a) 10/7/46 (Date rec'd by registrar) (b) Huntington Williams

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5- 1946, at 9 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/5/46 at 9:30 P. M.
(b) Where did injury occur? Columbia Asylum Circuit - Balto Co
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Mendelson M.D.
Medical Examiner.
Date signed 10-7-46

A337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44337
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 Alto Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Alto Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Seldin

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-3723

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Bobroisker, Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Presser

FATHER
12. Name Hyman Seldin
13. Birthplace Bobroisker, Russia

MOTHER
14. Maiden Name Judith ?
15. Birthplace Bobroisker, Russia

16 (a) Informant Isdaore Seldin
(b) Address 3310 Alto Road

17 (a) Burial (b) Date thereof Oct. 7, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Oct 1946 (b) Huntington Williams, MD
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 19 to 10/6 1946, and that I last saw h alive on 10/6/46 19

Immediate cause of death Coronary artery, Sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emanuel Bookman

Address 7904 Rhett Rd Date signed 10/7/46

VS 180

correct age is especially important. Physicians: please write the

G44338

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G44338
CERTIFICATE OF DEATH 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2151 Lorraine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Laura Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Married

6 (b) Name of husband or wife John Stewart
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) March 9, 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	6	25		

9. Birthplace Cambridge, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Wheeler
13. Birthplace Md

MOTHER
14. Maiden Name Annie E. Condon
15. Birthplace Md

16 (a) Informant Mr. John Stewart Jr.
(b) Address 1008 Shamrock Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F. Henry Inc.
(b) Address 714 Light St

19 (a) 10-7-1946 (Date received by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1946, at 11:40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1946 to 10-4 1946, and that I last saw h.. alive on 10/4 1946.

Immediate cause of death	Duration
Acute subdural hematoma	10 hours
Due to fracture, skull, right parietal region.	10 hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 53-00
(b) Date of occurrence 10-4-46 at 11 A. M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? No.
(Specify type of place)
(e) Means of injury Fell down stairs.
23. Signature Laurence J. Carmon M. D.
Address St Agnes Hosp. Date signed 10-4-46

Howard J. Sheeding, M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44339 ✓ G44339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor P. Dorr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife (Maiden name) Dorsey Dorr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21-1872

8. AGE: Years 74 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Office Attendant

11. Industry or business M D's Office

FATHER
12. Name Geo. G. Peterman
13. Birthplace Pa

MOTHER
14. Maiden Name Mary L. Buchlmann
15. Birthplace Pa

16 (a) Informant Mr. C. H. Peterman
(b) Address 2706 Evergreen ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8-46 (month) (day) (year)

(c) Cemetery or crematory Mount Peace
Location Philadelphia Pa

18 (a) Funeral director Geo. L. Berger Sr
(b) Address 1512 Hollins St

19 OCT 7 1946 (Date received by local registrar) (b) Huntingdon Pennsylvania (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946 at 7.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 4 1946 and that I last saw h[illegible] alive on Oct 4 1946.

Immediate cause of death — Duration

Acute Vascular Acc[illegible]

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel D Gabry M.D.
Address Sinai Hospital Date signed 10/7/46

G44340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44340 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 Grantley Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Grantley Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary F. Burton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife J. Elmer Burton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1876

8. AGE: Years 70 | Months — | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name John A. Devall
13. Birthplace Maryland

MOTHER 14. Maiden Name Anna Ford
15. Birthplace Maryland

16 (a) Informant Mrs. Lawrence Burton
(b) Address 721 Grantley Stree

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8-1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

19 (a) OCT 7 - 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1946 at 8-55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10, 1946 to Oct 4, 1946, and that I last saw h[illegible] alive on Oct. 4 1946.

Immediate cause of death
Congestive Heart Failure — Duration 3 Days
Due to Malignant Hypertension — 4 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas Smith, Jr. M.D.
Address 1933 W. Baltimore Date signed 10/5/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44341 Dver

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G44341

Please write the causes of death clearly and legibly. Physicians: please see that all items are correct as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts.,
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21½hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 21½ Hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4056 Hickory Ave.,
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Henry

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 5. 1946

8. AGE: Years	Months	Days	If less than one day
			21 hr. 30 min.

9. Birthplace Bon Secours Hospital (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr. Thomas W.L. Henry
13. Birthplace Maryland

MOTHER
14. Maiden Name Mrs. Ruth Hershey ~~Henry~~
15. Birthplace Penn.

16 (a) Informant Thomas W.L. Henry
(b) Address 4056 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1946 (month) (day) (year)
(c) Cemetery or crematory Beckleysville
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Local Registrar) (b) Huntington Williams Registrar

OCT 7 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6/46 19 4:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5/46 19 to 10/6/46 19 and that I last saw h im alive on 10/6/46 19

Immediate cause of death	Duration
premature birth	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Worthington Jr. M. D.
Address Date signed

1342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Snowden (Lillie Mae) (Lilliam)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-90

8. AGE: Years 55. | Months 9 | Days 10 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Jessie Gillard
13. Birthplace Md

MOTHER: 14. Maiden Name Lucy Gibbs
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Carrollton Ave

OCT 7 - 1946 (Date rec'd by Local Registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1946 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1946 to Oct 4 1946 and that I last saw h[illegible] alive on Oct 4 1946.

Immediate cause of death: Myocardial infarction due to coronary thrombosis — Duration: 24 hours

Due to Arterio-sclerosis and Hypertension — Duration: several years

Due to Carditis failure — Duration: [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. J. Gans
Address Johns Hopkins Hospital Date signed 10/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G44343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 St Paul St.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 St Paul St (If rural give location)
(e) Citizen of foreign country? - No - (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Ellis Briggs

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 218-18-5032

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) Dec-9-1897
8. AGE: Years 48 Months 9 Days 27 If less than one day hr. min.
9. Birthplace Wilmington Del. (Town, county, and state)
10. Usual Occupation Specialist Oculist
11. Industry or business Dr. L. B. Whitham

FATHER
12. Name Judd F. Briggs
13. Birthplace Kansas City - Mo.

MOTHER
14. Maiden Name Eleanor Lewis
15. Birthplace Upland - Penna

16 (a) Informant Mrs E. L. Briggs - mother
(b) Address 1700 St Paul St.
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-7-46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.
18 (a) Funeral director Stuart H. Romula,
(b) Address 108 W North Ave.
19 (a) Date received OCT 7 1946 (b) Williamsport Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1946, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944, to Oct-6 1946, and that I last saw h.. alive on Oct-4 1946.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	years
Due to (b) Rheumatic Heart Disease	years
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 28 E. Preston St Date signed 10/7/46

Huntington

X

G44344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G44344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3120 Presbury St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Presbury St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Edward Colliflower, Sr.

3 (b) If veteran, name war W.W. 1

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary R. Colliflower

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1899

8. AGE: Years 47 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Copy Editor

11. Industry or business Govt. Printing Office

FATHER
12. Name James E. Colliflower
13. Birthplace Md.

MOTHER
14. Maiden Name Sadie Delcher
15. Birthplace Md.

16 (a) Informant Mrs. Mary R. Colliflower
(b) Address 3120 Presbury St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director S. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) OCT 7 - 1946 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 11.30

20. DATE OF DEATH Oct. 6, 1946, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1946 to Oct 6 1946, and that I last saw h alive on Oct 5 1946

Immediate cause of death	Duration
Cardio-Vascular-Nephritis	10 mos.
Due to uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Bruns and Hood M. D.
Address 222 E. Garrison Blvd. Date signed 10/7/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G44345 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1450 Battery ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1450 Battery ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward S Klausner

3 (b) If veteran, name war No | 3 (c) Social Security Account No. 216-10-0297

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1863

8. AGE: Years 62 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, or state)
10. Usual Occupation Factory Foreman
11. Industry or business Paper Hanger
FATHER 12. Name Gustave Klausner
13. Birthplace Germany
MOTHER 14. Maiden Name Emma Frank
15. Birthplace Balto Md

16 (a) Informant Mrs Lillian Bissell
(b) Address 1412 Rainbow Ave Lbrk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1946 (month) (day) (year)
(c) Cemetery or crematory Lodge Rd
Location B. C. & C.

18 (a) Funeral director C. Regan Evans & Son
(b) Address 1411 E Baltimore St

19. (a) [illegible] (b) Registrar
(Date received by registrar)

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1946 to 10/5 1946.
and that I last saw deceased alive on 10/5 1946

Immediate cause of death	Duration
Pulmonary Endocarditis	6 mos.
Due to Arteriosclerosis	1 yr
Due to Hypertension	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Mullally M. D.
Address 1279 Mulberry W Date signed 10/7/46

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

Registered No. G44346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 St. Ambrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frampton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Susie S. Kirkman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Talbot Co. Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James T. Frampton
13. Birthplace Talbot Co. Md.

MOTHER
14. Maiden Name Sarah Bartlett
15. Birthplace Talbot Co. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT 9 1946 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cemetery
Location Easton, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave.

OCT 7 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1946, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Extradural Hemorrhage

Due to

Other Conditions Fracture of skull, fractured ribs, lacerations of brain.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 27/16
(a) Date of injury 10-2- at 6:45 P.M.
(b) Where did injury occur? Park Heights - Northern Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by street Car

23. Signature Thomas J. Waddell M.D.
Medical Examiner.
Date signed 10-7-46

G44347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1112

G44347 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 Clarkson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 73
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Clarkson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Gauer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles Henry Gauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1870

8. AGE: Years 76 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Jacob Blum
13. Birthplace Germany
14. Maiden Name Elizabeth Fritz
15. Birthplace Germany

16 (a) Informant Gertrude Schanz
(b) Address 1405 Clarkson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8. 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mr. Mrs. John H. Seufert Son
(b) Address 5311 Edmondson Ave.

OCT 7 - 1946 Date received by Registrar — Washington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946; at 12 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19.

Immediate cause of death — Duration

Bronchial Asthma — 15 yrs

Due to

Due to

Other Conditions Myocardial Insufficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent M. Messina M. D.
Address 1403 S Charles ST Date signed 10/5/46

Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

Dr. Kunk G44318
3201 Beverly Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √102

G44318
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 North Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 247 North Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. O'Hara
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Agnes E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1893

8. AGE: Years 53 | Months 3 4 | Days 31 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Senoir Clerk
11. Industry or business City Hall

FATHER
12. Name Francis P. O'Hara
13. Birthplace Ireland

MOTHER
14. Maiden Name Lucille Lingan
15. Birthplace Md.

16 (a) Informant Mrs. Agnes E. O'Hara
(b) Address 247 North Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946, at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27, 1946 to Oct 4, 1946 and that I last saw him alive on Oct 2 1946

Immediate cause of death: Malignant Hypertension — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad Thompson M. D.
Address 2529 Barton Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44349

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G44349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5821 Jonquil Aye
(c) Hospital or institution:

27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5821 Jonquil Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lena Belgin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mr. I. Coplin
(b) Address 5821 Jonquil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-41 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Cem.
Location Brooklyn, N.Y.

18 (a) Funeral director Jayk Lewis Inc.
(b) Address 1439 E. Balto. St.

OCT 7 - 1946 Huntington Williams Mill
(Date rec'd by Reg.) (Signature of Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-46 19 , at 7:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24- 1946 to 10-7 1946, and that I last saw her alive on 10-7- 1946.

Immediate cause of death	Duration
Carcinoma of Lt. Breast with Metastasis to Lt. Lung	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. N. Nelson M. D.
Address 617 N. 40th St. Date signed 10-7-46.

G44350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44350 Registered No. 1370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Salisbury. (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 E. Church St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Fred Gordy
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married.
6 (b) Name of husband or wife Virginia Gordy
6 (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) October 12 - 1869
8. AGE: Years 76 Months 11 Days 25 If less than one day hr. min.
9. Birthplace Salisbury Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self
FATHER 12. Name William W Goldy
13. Birthplace Delaware
MOTHER 14. Maiden Name Hester A Elephant
15. Birthplace Maryland
16 (a) Informant Virginia B. Grady
(b) Address 606 E. Church St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-46 (month) (day) (year)
(c) Cemetery or crematory Parsons Location Salisbury Md.
18 (a) Funeral director Hollinsbury & Co
(b) Address Salisbury Md.
19 (a) 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1946; at 8:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1946 to 10-7 1946 and that I last saw h[illegible] alive on 10-6 1946
Immediate cause of death Cardiac Failure — Duration
Due to Uremia & Toxemia
Due to Senile - Urinary infection
Other Conditions BPA
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James A Vaughan, Jr M. D.
Address University Hospital Date signed 10-7-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Covington Williams, M.D.

VS 150

P.C.H. M.D.

G44351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G44351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 E Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Kochanoski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-97

8. AGE: Years 49 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

PARENTS
12. Name Joseph Kochanoski
13. Birthplace Poland

SURVIVING SPOUSE
14. Maiden Name ? ?
15. Birthplace Poland

16 (a) Informant Helen Kochanoski
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Paterson Hall Rd.

18 (a) Funeral director Lichy & Zeiler
(b) Address 403 N. Gay St.

19 (a) [illegible] Registrar
(Date received) Washington Hollands, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1946 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1946, to Oct 4 1946, and that I last saw [illegible] alive on Oct 4 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Cirrhosis of liver & Anemia	
Due to Chronic alcoholism	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C Austrian
Address The Johns Hopkins Hosp Date signed 10-7-46

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

X

G44352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registered No. G443528

ZH. G44352 102439

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3months & 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Coldspring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mery Kielian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7th 1884

8. AGE: Years 61 Months 9 Days 27 If less than one day hr. min.

9. Birthplace Radomyar, Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Giza
13. Birthplace Poland

MOTHER
14. Maiden Name Kathryn ? Dudek
15. Birthplace Poland Poland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadoski & Sons
(b) Address 1808 Eastern Avenue

19 (a) Date received OCT 9 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4th 1946 19 , at 3.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 19 46 to Oct. 4 19 46, and that I last saw h er alive on Oct. 4th 1946.

Immediate cause of death: Bronchopneumonia, Putaba — Duration: 2 days

Due to: Arteriosclerotic Cardio- — 4 yrs.

Due to: vascular Disease

Other Conditions: Intertrochanteric fracture Left Femur — 2 mos.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 27-14
(b) Date of occurrence 6-28-46 (or about) at M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell down stairs
23. Signature Rankin B. Mitchell M. Don
Address Balt. City Hosp. Date signed 10-4-46

Approval of Medical Examiner
For C. J. R. Oaks, by Howard J. Andersen, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G44353

1. PLACE OF DEATH: D.I.A.
(a) Baltimore City, Maryland
(b) Street address 1834 McHenry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 McHenry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara D. Wintermyer

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1886

8. AGE: Years	Months	Days	If less than one day
59.	10	25	hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John J. Wintermyer
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden Name Mary Ellen Lavin
15. Birthplace Frederick, Md.

16 (a) Informant Mrs Lourdine Sidgers
(b) Address Route 6, Cumberland, Md.

17 (a) Burial (b) Date thereof Oct. 9, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peter & Paul Catholic
Location Cumberland, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1210 W. Lombard St

19 (a) Received and registered OCT 7 1946 by Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1946 at 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Fuhrman M.D.
Medical Examiner.
Date signed 10/7/46

G44354

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 937

G44354

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6024 Stanton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

(a) FULL NAME John E. McCauley.

3. (b) Social Security Number

4. Color or race	5.(a) Single, married, widowed, or divorced
White	Single

(b) Name of husband or wife

6.(a) If alive, give age ____ years

Birth date of deceased (mo., day, yr.) June 21, 1868

AGE: Years	Months	Days	If less than one day
78	3	12	____ hrs. ____ min.

Birthplace Maryland.
(State, county, and state)
Usual occupation Retired.
Industry or business Mill Hand.
12. Name John F. McCauley.
13. Birthplace Maryland.
14. Maiden name Mary E. Johnson.
15. Birthplace Maryland.
Informant Mrs. Mary F. Mantua
Address 6026 Stanton Ave.
Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5, 1946 (month) (day) (year)
Cemetery or crematory St. Mary's
Location Hanover.
Funeral director Clements & Donovan
Address 3615-17 Chestnut Ave.
10/4 1946 Dr. Hadrit
(Date received by registrar) Registrar
OCT 7 1946 Huntingtown, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1946, at 1 30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1946, to Oct 3 1946 and that I last saw h. alive on Oct 3d 1946

Immediate cause of death	DURATION
a. Arterio Sclerotic heart	6 hrs
Due to a. arterio sclerosis	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE P. W. Hadrit M. D.
Address 2020 N. Charles Date signed 10/4/46

G44355 BC# 500498. D55990 BALTIMORE CITY HEALTH DEPARTMENT G44355

CERTIFICATE OF DEATH 119a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Emma (?) Hangnore.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9. 9. 46.

8. AGE: Years	Months	Days	If less than one day
		0 1 2 3	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? ?.
13. Birthplace ? ?.

MOTHER
14. Maiden Name Emma Hangnore
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 7 1946 Huntington Williams MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2. 1946, at 1.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1946 to Oct 2 1946 and that I last saw him alive on Oct. 2. 1946.

Immediate cause of death: DIARRHOEA OF THE NEWBORN — Duration: 9 days

Due to

Due to

Other Conditions PREMATURITY — Duration: LIFE

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H. Nandy

Address JOHNS HOPKINS HOSP. Date signed 10/2/46 M. D.

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I 6 Free
G44356

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1936

G44356
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Baltimore Co.
(c) Hospital or institution: Baltimore Co. Tuberculosis Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hilscher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife John Hilscher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1880

8. AGE: Years 66 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Joseph Sallo
13. Birthplace Bohemia

MOTHER
14. Maiden Name —
15. Birthplace Bohemia

16 (a) Informant John Hilscher
(b) Address 1009 Ensworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-46 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location Balto Md

18 (a) Funeral director Hugh Gruchalow
(b) Address 900 N Chester St

19 (a) (Date rec'd by Registrar) (b) Registrar

OCT 9 1946

VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946 at 1:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1946 to Aug 5 1946 and that I last saw h[illegible] alive on August 4 1946

Immediate cause of death	Duration
CEREBRAL EMBOLISM	6 - HRS.
Due to ENDOCARDITIS (SUB-ACUTE)	8 MO -
Due to MYOCARDITIS	5 YRS.
Other Conditions CEREBRAL EMBOLISM	3 DAYS

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas R Kleinow M. D.
Address 3803 Edmondson Ave Date signed 10/7/46

X

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G44357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A 159

Registered No. G44357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Reisterstown Rd.
(e) Citizen of foreign country? (If rural, give location) No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hastings.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/46

8. AGE: Years | Months | Days: 13 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Wilbur J. Hastings
13. Birthplace Md.

MOTHER — 14. Maiden Name Louise ?
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 7 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1946 at 3 07 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1946 to Oct 3 1946 and that I last saw h[illegible] alive on Oct 3 1946

Immediate cause of death: Prematurity. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Emanuel Appel

Address Md. Gen. Hosp. Date signed 10/3/46

VS 150

G44358 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600

G44358 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE STS.
(c) Hospital or institution:
UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. GILMOR ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-46

8. AGE: Years	Months	Days	If less than one day
—	—	—	6 hr. 7 min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name Forrest Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name SADIE Cornish
15. Birthplace MD.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 7 1946 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1946, at E.or P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1946, to 10-1 1946, and that I last saw him alive on 10-1 1946.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to INTRA-CRANIAL HEMORRHAGE

Due to Rapid Labor

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Beverman M. D.
Address University Hosp. Date signed 10-1-46

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G44359 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere ave & Greenspring
(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) U.K

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere ave & Greenspring ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE KRESSIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Wd

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Russia

MOTHER 14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Levindale Hospital
(b) Address Belvedere Ave & Greenspring

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rodedale
Location Hamilton ave

18 (a) Funeral director A.L. Levinson & Bros.
(b) Address 1124-26 W. North ave

19 (a) Date 1946 (b) Registered number Filed for Williams Register

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1946, at 315 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19 1944 to 10-7 1946 and that I last saw her alive on 10-7 1946.

Immediate cause of death: Cerebral thrombosis — Duration
Due to: arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 10-7-46

VS 150

X

G44360 G44360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2521 N. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days) 68yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 N. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Henrietta M. Kraemer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-6103

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22. 1878

8. AGE: Years 68 | Months 1' | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerical work.

11. Industry or business H. K. & B. (Retired)

FATHER 12. Name Henry Kraemer

13. Birthplace Germany

MOTHER 14. Maiden Name Louisa Becker Louisa Bleker

15. Birthplace Baltimore Md.

16 (a) Informant Miss Annie Kraemer

(b) Address 2521 N. Fairmount Ave.

17 (a) Burial (b) Date thereof Oct. 9, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director Wilbur Lawrence

(b) Address 1510 Liberty Heights Ave.
Huntington Williams, M.D.

1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1946, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1944 to Oct. 6 1946 and that I last saw h[illegible] alive on Oct 6 1946

Immediate cause of death

Chr. Myocarditis — Duration 3 yrs

Due to

Due to Chr. Interstitial nephritis — 1 yr

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Brown

Address 1663 W. North Ave. Date signed 10/8/46

VS 150

G44361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy "B" Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-46

8. AGE: Years | Months | Days 22 | If less than one day hr. min.

9. Birthplace Frederick Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Miller
13. Birthplace ? Md

MOTHER
14. Maiden Name Violet Butler
15. Birthplace ? Md

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-46 (month) (day) (year)
(c) Cemetery or crematory Bethel Church of God
Location Winfield Carroll Co. Md

18 (a) Funeral director Luther H. Walker
(b) Address Winfield Md

19 (a) OCT 8 - 1946 (Date rec'd by registrar) (b) Huntington Wilkinson M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1946 at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1946 to Oct 7 1946 and that I last saw ~~him~~ alive on Oct 7 1946

Immediate cause of death: DIARRHOEA OF THE NEWBORN — Duration: 18 days

Due to

Due to

Other Conditions PREMATURITY — LIFE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul H. Harding M. D.
Address JOHNS HOPKINS HOSP Date signed 10/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44362 Kendzejewski

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1126

G44362 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland Annex Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, give NEAREST city or town)
(d) Street No. 907 S. Eden Place (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Kendzejeski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Wht	WIDOWED

6 (b) Name of husband or wife MARTIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 July 1890

8. AGE: Years	Months	Days	If less than one day
56	2	25	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER 12. Name UNKNOWN
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant JOHN KENDZEJEWSKI
(b) Address 2228 EASTERN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/8/1946 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location DUNDALK AVE

18 (a) Funeral director John M. Huber
(b) Address 401 S. Chester St.

OCT 8 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1946, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1946, to Oct. 4 1946, and that I last saw him alive on 10/4 1946.

Immediate cause of death Rt. heart failure

Duration

Due to Status Cothmotica - prostatectomy

Due to Chr. bronchitis

Other Conditions Chr. bilateral hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. McGowan M. D.
Address Md. Gen. Hosp. Date signed 10/6/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

106 D

4363 G44363

BALTIMORE CITY HEALTH DEPARTMENT X Registered No.

CERTIFICATE OF DEATH 1222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balt Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) ~~City or~~ town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Masonic Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Harry~~ Harry D. Hieatzman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mollie A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1868

8. AGE: Years 78 | Months 4 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Own

FATHER 12. Name Mathias Hieatzman
13. Birthplace Unknown

MOTHER 14. Maiden Name Marguerite Park
15. Birthplace Balto. Md.

16 (a) Informant Records Masonic Home
(b) Address Cockeysville Md.

17 (a) Burial (b) Date thereof 10/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Oct 1946 at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Oct 1946 to 6 Oct 1946 and that I last saw h(?) alive on 6 Oct 1946.

Immediate cause of death Shock

Due to Operative Hemorrhage.

Due to

Other Conditions Hypertension. Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation 6 Oct 46

Major findings of operation: Hemorrhage Stump Inguinal Hernia

of autopsy Surgical Shock

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. J. Wadsworth

Address W. B. & G. Hospital Date signed Oct 6, 46

X

G44364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G44364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Le Marquand
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1865
8. AGE: Years 81 | Months 5 | Days 9 | If less than one day hr. min.
9. Birthplace Channel Island, New Jersey (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Joseph Acourt
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Kelly
15. Birthplace Ireland

16 (a) Informant Percy LeMarquand
(b) Address 115 46th Ave S.E. Glenburnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 Filed OCT 8 — 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 October 1946 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Sept 1946 to 6 Oct. 1946 and that I last saw h e alive on 6 Oct 1946

Immediate cause of death: Acute Circulatory Collapse — Duration 12 hrs.
Due to Lobar Pneumonia — 48 hrs.
Due to —
Other Conditions Fracture, Left Forearm — 12 days
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident Fall
(b) Date of occurrence Sept. 24, 1946 at 10 A M
(c) Where did injury occur? Broadneck A.A.Co. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? AT HOME While at work?
(Specify type of place)
(e) Means of injury Fell down stairs

23. Signature Thomas M. Hutchins
Address South Balto Gen. Hosp. Date signed 7 Oct. 1946
Howard J. Sweeney, M.D.

VS 150

4365 BALTIMORE CITY HEALTH DEPARTMENT G14365
CERTIFICATE OF DEATH ✓ 46E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Balto. General Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna S. Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Guy H. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1889

8. AGE: Years 56 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christopher Schindele
13. Birthplace Germany

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace

16 (a) Informant Guy H. Wilson
(b) Address 604 Montpelier St.

17 (a) Burial (b) Date thereof 10/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

OCT 8 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1946 at 3:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14, 1946 to Oct. 7, 1946 and that I last saw her alive on Oct. 7, 1946

Immediate cause of death: Cardio respiratory failure — Duration
Due to: Carcinoma of colon
Due to:
Other Conditions: Hypertensive arteriosclerotic cardiovascular
(Include pregnancy within 3 months of death)
Date of operation Sept. 28, 1946
Major findings of operation: Unresectable cancer of colon.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 10/9/46

Please write plainly with unfading ink. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G44366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44366

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 118 days
(e) Length of stay in Baltimore (yrs., mos., or days) 118 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NC (b) County
(c) City or town Beaufort (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Anne St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ireland, John Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No. 246-16-5653

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1898

8. AGE: Years 48 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Hobucken, NC (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Seafarer

FATHER
12. Name Geo. W. Ireland
13. Birthplace Hobucken, NC

MOTHER
14. Maiden Name Ann Lupton
15. Birthplace Hobucken, NC

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Morehead City
Location North Carolina

18 (a). Funeral director Williams Cook Inc
(b) Address 127 St. Paul St.

19 OCT 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1946, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1946, to Oct. 6 1946, and that I last saw him alive on Oct. 6 1946.

Immediate cause of death Carcinoma of lung with metastasis to adrenal and brain and liver. — Duration UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 10/7/46

VS 190

PLEASE WRITE CLEARLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Registered No. G44367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2720 Edmondson Ave
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Dawson

3 (b) If veteran, name war:

3 (c) Social Security Account No. No

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Mattie M.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept 26-1864

8. AGE: Years 82 | Months | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired. Ship Carpenter

11. Industry or business

FATHER
12. Name Thomas Dawson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name ? Pontier
15. Birthplace Baltimore Md.

16 (a) Informant Mattie M Dawson
(b) Address 2720 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Bal Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul St

19 OCT 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6- 1946 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct 6 1946 and that I last saw h[illegible]alive on Oct 5 1946.

Immediate cause of death	Duration
Coronary Thrombosis	5 days
Due to Arteriosclerosis	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer C. Todd
Address 2408 St Paul St Date signed 10/7/46 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 644368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 728 Homestead St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Norton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Matthew H. Norton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1876

8. AGE: Years 69 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Philadelphia Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph P. Hart
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Powell
15. Birthplace Ireland

16 (a) Informant Florence Norton
(b) Address 728 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9 1946 (month) (day) (year)
(c) Cemetery or crematory Loudoun Memorial
Location Taylor Ave.

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 E. Paul St.

19 OCT 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1946, at 3:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1946 to Oct. 6, 1946 and that I last saw her alive on Oct. 6, 1946.

Immediate cause of death

Uremia. Duration 4 days

Due to Nephritis Duration

Due to Arteriosclerosis Disease Duration 1½ yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest Lewis, M.D.
M.D.

Address 1601 N. Broadway Date signed 10/9/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G44369 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4525 Schenley Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4525 Schenley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Hunter

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Mary Jane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1865

8. AGE: Years 81 Months 7 Days 5 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name James K. Hunter

13. Birthplace Baltimore

MOTHER 14. Maiden Name Laura Cloud

15. Birthplace Baltimore

16 (a) Informant Wm H. Hunter Jr.

(b) Address 4525 Schenley Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location Balto.

18 (a) Funeral director Wm Cook Inc.

(b) Address 1217 St Paul St

19 (a) (b) Registrar

Certificate rec'd by registrar OCT 8 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946, at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to Oct 5 1946, and that I last saw him alive on October 4 1946.

Immediate cause of death: Cerebral thrombosis — Duration: 2 days

Due to: arteriosclerosis — 1 year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elbert L. Mortimer Jr. M. D.

Address 2708 St Paul St Date signed 10/9/46

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44370 WARTHEN G44370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 W Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E Warthen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles W. Warthen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20 1866

8. AGE: Years 80 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Herman Muhly
13. Birthplace Germany Calif

MOTHER 14. Maiden Name Elizabeth Bauer Bauer
15. Birthplace Balto. Md.

16 (a) Informant John H. Muhly
(b) Address 3204 Normont Ave.

17 (a) Burial (b) Date thereof 10/9/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) OCT 8 1946 (b) Huntington Williams, M.D.
(Date filed by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1946, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Past 2 years 19 to 19 ; and that I last saw h alive on Oct 7 1946.

Immediate cause of death: Cancer of left Breast — Duration 5 yrs.
Due to
Due to
Other Conditions Metastasis to Lungs — 2 mos.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H Mcvay M. D.
Address 6 W Fayette St Date signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

X

G44371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G44371

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Bel Air Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA Holthaus (HAMMERBACHER)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife: Jacob Holthaus (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26 1870.

8. AGE: Years	Months	Days	If less than one day
76	7	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation housewife at home.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mildred Emery
(b) Address 2109 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery Location North Ave + Rose St

18 (a) Funeral director Schumeyer
(b) Address 3601 E Madison St.

19 OCT 8 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Oct 1946 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Sept 1946 to 6 Oct 1946 and that I last saw her alive on 6 Oct 1946

Immediate cause of death: Cardio Respiratory failure
Due to Gangrene of Leg
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells M.D.
Address 1 E Pleasant Date signed 10-6-46

VS 150

Huntington Williams, M.D.

G44372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G44372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID BENTON SMELSER

3 (b) If veteran, name war	3 (c) Social Security Account No.	
none	none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Clara R. Smelser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1865

8. AGE: Years	Months	Days	If less than one day
80	11	4	hr. min.

9. Birthplace Carrol Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Smelser
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mr. Benton Smelser, Son
(b) Address 2824 Parkwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/46 (month) (day) (year)
(c) Cemetery or crematory Krider's Cem.
Location Carrol Co., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 9 1946 (Date received by registrar) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1946 at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 45 to Oct 6 1946, and that I last saw him alive on Oct. 5, 46

Immediate cause of death — Duration

Arteriosclerosis — 5Yrs

Due to

Cereberal Hemorrhage — 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Helm
Address 2737 W. Lanvale Date signed 10/7/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H. C. Helm

G44373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G44373 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.,
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Keswick & 40th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Stoll KATHERINE STOLL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1885

8. AGE: Years	Months	Days	If less than one day
60	10	4	hr. min.

9. Birthplace Lebanon, Pa
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Rev. Geo. Stoll
13. Birthplace Wurtemberg, Germany

MOTHER
14. Maiden Name Sarah Pfeiffer
15. Birthplace Lancaster, Pa.

16 (a) Informant Home for Incurable Records
(b) Address 700 W. 40th St. Md. 10

17 (a) Burial (b) Date thereof 10/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) 10/8 1946 (b) Registered by Wm

VS 2

MEDICAL CERTIFICATION 4:30 AM

20. DATE OF DEATH Oct. 6, 1946, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1938 to Oct 6 1946, and that I last saw h[illegible] alive on Oct. 5 1946.

Immediate cause of death	Duration
Metastatic Carcinoma of Brain	2 months
Due to Ca Carcinoma of Breast removed Jan. 1946	5 months
Due to	
Other Conditions Congenital Spondylolisthesis (Include pregnancy within 3 months of death)	60 yrs.

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolff M. D.
Address 11 East Chase St. Date signed Oct 8 1946

G44374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 52a

G44374 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 W. North
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter S. Baum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary A. Baum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 9th 1874

8. AGE: Years	Months	Days	If less than one day
67	6	28	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Restaurant

FATHER
12. Name (Unknown) Baum
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Armistead Bayon
(b) Address 2316 W. North Ave

17 (a) Burial (b) Date thereof 10/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) OCT 8 1946 (b) Huntington Whitestone, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1946, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1946 to Oct. 7, 1946 and that I last saw deceased alive on Oct. 2, 1946

Immediate cause of death Adeno — Carcinoma right Kidney. — Duration 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 30 1946.

Major findings of operation: Adeno-Carcinoma R. Kidney - Metastasis Hepatic.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ira Symmonds M.D.
Address Medical Arts Bldg Date signed 10/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44375 G44375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 477 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3729 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3729 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Sheppard Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alta M. nee Watkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1884

8. AGE: Years 62 Months 4 Days 22 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Yard Foreman

11. Industry or business B. & O. R. R.

FATHER 12. Name Bailey

13. Birthplace Va.

MOTHER 14. Maiden Name Unknown

15. Birthplace Va.

16 (a) Informant Mrs. Alta M. Bailey

(b) Address 3729 Wilkens Ave

17 (a) Burial (b) Date thereof Oct. 9/46.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Pk.

Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Whittle

(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) OCT 8 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 11:55PM

20. DATE OF DEATH Oct. 6th 1946. (Hour of death)

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1946 to 10/6 1946 and that I last saw h.i. alive on 10/5 1946.

Immediate cause of death Coronary Pulmonary

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Franklin M. D.

Address 1123 S. Charles St Date signed

VS-199

H. D. Franklin ×

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5C-M / G44376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44376 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4011 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward H. Esender

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Ella Griffiss Esender 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1875

8. AGE: Years	Months	Days	If less than one day
71	1	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Thomas Esender
13. Birthplace Md.

MOTHER 14. Maiden Name Emily Slincomb
15. Birthplace Md.

16 (a) Informant Mrs. Ella G. Esender
(b) Address 4011 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6- 1946, to Oct 5 1946, and that I last saw h[illegible] alive on Oct 3 1946

Immediate cause of death	Duration
Cardiac Standstill	minutes
Due to Arteriovascular Respiratory Disease	7
Due to	
Other Conditions Cardiac Failure & Enlargement	5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Pearl Pasa, M.D.
Address 4001 Wilkens Ave Date signed 10-7-46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

Huntington Hillcrest

G44377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V122B

G44377 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw & Wilkens Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Walnut ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen B. Travers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife Late Dr. Edgar E. Travers 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 21. 1897

8. AGE: Years 49 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name Michael Mc Gillen
13. Birthplace Ireland

MOTHER 14. Maiden Name Roseann Troy
15. Birthplace Ireland

16 (a) Informant Mrs. Roseann Taylor
(b) Address 626 Ingleside ave. (Cat.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Nitske
(b) Address 4101 Edmondson ave.

19 (a) (Date rec'd by registrar) OCT 8 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1946, to 10/6 1946, and that I last saw h[illegible] alive on 10/6/ 1946.

Immediate cause of death: Paralytic Ileus — Duration

Due to Extreme distention of entire gastro-intestinal tract

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stuart D. Rizika M. D.
Address St Agnes Hosp Date signed 10/6/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44378 BALTIMORE CITY HEALTH DEPARTMENT G44378

CERTIFICATE OF DEATH (93) Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.
(b) Street address 2008 Fountain St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Fountain St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jan or John Kozlowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-5445

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	(married)

6 (b) Name of husband or wife (Mary Anna)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 51			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laboer
11. Industry or business American Chemical Co

FATHER
12. Name Adam Kozlowski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria
15. Birthplace Poland

16 (a) Informant Maryanna Kozlowski
(b) Address 2008 Fountain St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co. Md.

18 (a) Funeral director Wm. S. Fiszkowski
(b) Address 2007 Eastern Ave

19 (a) OCT 8 1946 (b) Washington Nolliaux, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1946, at 11:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Ref. Sabrinski M.D. Medical Examiner.
Date signed 10/6/46

VS 181

G44379 — BALTIMORE CITY HEALTH DEPARTMENT — G44379 (Registered No.)

CERTIFICATE OF DEATH 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 4506 Frederick Rd

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 6014 Shady Spring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Florence A. Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Loyd W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 19, 1886

8. AGE: Years 59 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Insurance Agent

11. Industry or business: Ramsay Bat...

FATHER
12. Name: George W. Rabold
13. Birthplace: Md

MOTHER
14. Maiden Name: Anna Purcell
15. Birthplace: Md

16 (a) Informant: Grace W. Schaefer
(b) Address: 6014 Shady Spring Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year): 10/9/46

(c) Cemetery or crematory: Western
Location: Edmondson Ave.

18 (a) Funeral director: M. W. E. Dyer's Sons
(b) Address: Loudon Park Avenue

19 (...) OCT 8 - 1946 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1946 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Oct 6 1946, and that I last saw h[e] alive on Oct 4 1946.

Immediate cause of death: Exhaustion — Duration 1 day

Due to: Carcinoma of Breast

Due to: Metastases to Lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Charles J. Mell
Address: 5276 Park Heights Date signed: Oct 7 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G44380 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Greene Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5519 Delma Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Earl Looker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Genevieve Smith Looker
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1888

8. AGE: Years	Months	Days	If less than one day
58	8	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business B & O. R.R.

FATHER
12. Name — Unk
13. Birthplace —

MOTHER
14. Maiden Name — Unk
15. Birthplace —

16 (a) Informant Mrs Genevieve Looker
(b) Address 5519 Delma Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director M. R. Eichelberger & Son
(b) Address Frederick Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1946 at 11:25 P

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 6 1946, and that I last saw him alive on Oct 6 1946.

Immediate cause of death Coronary Embolism — Duration

Due to Pulmonary Embolism

Due to Atherosclerosis of femoral arty

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard J. Crow M. D.
Address University Hosp Date signed 10-7-46

100 B

VS 10-1946

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1219

Registered G44381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 N Kenwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 N Kenwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace S Wedmore Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1892

8. AGE: Years 53 Months 11 Days 24 If less than one day hr. min.

9. Birthplace Balto (Town, county and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER 12. Name Geo E Wedmore
13. Birthplace Balto

MOTHER 14. Maiden Name Mary F Brady
15. Birthplace Balto

16 (a) Informant Horace S Wedmore Jr
(b) Address 232 N Kenwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Hillen Funeral Home
(b) Address 2008 Orleans St

19 (a) (b) Registrar
(Date received by registrar)
OCT 8 - 1946
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1946, at 8 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Oct 6 1946, and that I last saw him alive on Oct 6 1946.

	Duration
Immediate cause of death Myocarditis.	6 mos
Due to Arteriosclerosis	3 Yrs
Due to	
Other Conditions CAR INT NEPH	3 Yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F Kavanagh M D
Address 538 N Calhoun St Date signed Oct 8 46

92

Fill in items carefully, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44382 — BALTIMORE CITY HEALTH DEPARTMENT — G44382 Registered No.

CERTIFICATE OF DEATH 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3034 Lynden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Lynden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

BORNER / FATHER
12. Name Isaac
13. Birthplace Russia
14. Maiden Name Tobie
15. Birthplace Russia

16 (a) Informant Harry D Cohen
(b) Address 3034 Lynden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-46 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herzing Run

18 (a) Funeral director Jack Levy Inc
(b) Address 439 E Balto St

19 (a) OCT 8 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1946, at 1:25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from February 4 1944 to Oct. 7 1946, and that I last saw h.C.V. alive on October 6 1946

	Duration
Immediate cause of death: Generalized Carcinomatosis	6 Months
Due to Carcinoma of Breast	2 years
Due to	
Other Conditions Hemiplegia, Cerebral accident (Include pregnancy within 3 months of death)	2 1/2 years

Date of operation Aug 1945
Major findings of operation: Carcinoma of Breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Levin M. D.
Address 2224 Eutaw Pl Date signed Oct. 7 1946

VS 150

X

B44383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47C

B 44383
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline
(c) Hospital or institution: St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Ensor St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence J. Popp

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-2202

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Marie E (Byrnes)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	14	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation General Maintenance
11. Industry or business Standard Gas Co.

FATHER
12. Name Martin Popp.
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Albina Hochn
15. Birthplace Germany

16 (a) Informant Marie E Popp.
(b) Address 1605 Ensor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/46 (month) (day) (year)
(c) Cemetery or crematory St Vincents Cemetery
Location Belair Road Balto Md.

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1946 to 10/5 1946.
and that I last saw h. alive on 10/5 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchogenic Ca of left Lung	
Due to	

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Bronchogenic Ca left lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. S. Downs M. D.
Address St Josephs Date signed 10/5/46

X

G44384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G44384 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 Myrtle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cassie Myers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 21

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace Va. (Town, county, and State)
10. Usual Occupation Beautician
11. Industry or business

FATHER
12. Name Hanige Hurt
13. Birthplace Va

MOTHER
14. Maiden Name Therpsa Jones
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katye R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received by registrar Oct 9 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 6 1946 and that I last saw her alive on Oct 6 1946.

Immediate cause of death: Uremia
Contributing factors: Cardiac failure
Due to: Chronic glomerulonephritis

Duration
4-5 wks.
1 wk.
10-12 mo.

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. T. Davis M. D.
Address Johns Hopkins Hospital Date signed 10/9/46

VS 150

G44385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G44385 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Preice St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Preice St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry R. Sample, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 1903

8. AGE: Years	Months	Days	If less than one day
42	11	21	hr. min.

9. Birthplace Bell Haven, Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Harry Sample, Jr.
13. Birthplace Bell Haven Va.

MOTHER
14. Maiden Name Maggie Black
15. Birthplace Accomac Co. Va.

16 (a) Informant Lillie Harmson.
(b) Address 688 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 19 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

OCT 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 19 46, at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 19 46 to Oct 7 19 46 and that I last saw h[illegible] alive on Oct 7 19 46. I last viewed dead body on Oct 7 19 46.

Malignant Hypertension — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Bowers

Address 717 Eden St. Date signed Oct 8 46

G44386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

G44386

File No. 372993

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Gilmor, St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Minters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-1-11

8. AGE: Years	Months	Days	If less than one day
34	11	5	hr. min.

9. Birthplace Md (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lawson Minters
13. Birthplace Va.

MOTHER
14. Maiden Name Linne Kellum
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 6 - 1946 at 12

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30- 1946 to 10-6- 1946 and that I last saw him alive on 10-6- 1946.

Immediate cause of death UREMIA AND CARDIAC FAILURE — Duration 4 WKS

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE — Duration 5 YRS

Due to — Duration

Other Conditions ASYMPTOMATIC NEURO SYPHILIS — Duration not known

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: MATERIAL APPROXIMATE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Freeman J. Stephens M. D.
Address Johns Hopkins Hospital Date signed 10-6-46

VS 150

93

G44387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) qrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ULYSSES G. HANSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret G. Hanson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1868

8. AGE: Years	Months	Days	If less than one day
77	11	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business City of Baltimore

FATHER
12. Name James Hanson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah J. Price
15. Birthplace Md.

16 (a) Informant Mrs. U. G. Hanson
(b) Address 1614 N. Broadway

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (a) Oct 8 — 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1946 at 8.40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1946 to Oct 7 1946, and that I last saw h alive on Oct 5 1946.

Immediate cause of death

	Duration
My arteriosclerosis	8 Mos.
Due to Arteriosclerosis	
Due to	
Other Conditions Cystitis - Defunctus Glans Penis (Include pregnancy within 3 months of death)	15 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lanahan Funeral Home
Address 1823 N. Monroe St. Date signed 10/7/46 M. D.

X

G44388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1328

G44388 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address # Calvert & Saratoga Sts
(c) Hospital or institution:
Mary Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? Italy (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Lombardo or Santo Sciacca

3 (b) **If veteran, name war**

3 (c) **Social Security Account No.** 217-03-3096

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) **Name of husband or wife** Carmella Lombardo
6 (c) **If alive, give age** 36 years

7. **Birth date of deceased (mo., day, yr.)** Feb. 1, 1888

8. AGE: Years	Months	Days	If less than one day
58 yrs	8	6	hr. min.

9. **Birthplace** Italy (town, county, and state)
10. **Usual Occupation** Laborer
11. **Industry or business** American Sugar Refinary

FATHER
12. **Name** Guy Lombardo Sciacca
13. **Birthplace** Italy

MOTHER
14. **Maiden Name** Mrs. Santa ?
15. **Birthplace** Italy

16 (a) **Informant** wife
(b) **Address** 900 E. Pratt St.

17 (a) **Burial** (Burial, cremation, or removal) (b) **Date thereof** Oct. 9, 1946 (month) (day) (year)

(c) **Cemetery or crematory** Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) **Funeral director** Frank Dellaliore
(b) **Address** 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 8 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Oct 6 1946, at 10:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4, 28 1946 to Oct 6 19 1946 and that I last saw h. alive on Oct 6 1946

Immediate cause of death Status Asthmaticus — Duration

Due to Cardiac Tamponade

Due to Tbc metastasis?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** James V. Minor, Jr. M.D.
Address Mercy Hosp. **Date signed** 10-6-46

X

G24389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓53

Registered No. G24389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2606 Fleet St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August G. Kaminski (Stein)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Pauline Raddke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1864

8. AGE: Years	Months	Days	If less than one day
82	0	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Fairfield Western Maryland Dairy

FATHER
12. Name Not.Known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Pauline Kaminski
(b) Address 2606 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Swartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) Date received OCT 8 1946 (b) Registrar's signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1946, at 11 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to Oct 1946 and that I last saw h[illegible] alive on Oct 4 1946

Immediate cause of death Squamous cell Carcinoma of Lung & Secondary metastatic Ca of Liver & Lungs

Duration

Due to Myocardial Insufficiency.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2529 Eastern Ave. Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47

G44390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2040 E.Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 E.Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Arata

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie Arata
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.12,1879

8. AGE: Years	Months	Days	If less than one day
67	6	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Arata
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Kate Connelly
15. Birthplace Balto. Md.

16 (a) Informant Mrs.Margaret Lecompte
(b) Address 2040 E.Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct.8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Lord
(b) Address 2024 Orleans St.

OCT 8 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct.5,1946 19 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1946 to Oct 5 1946 and that I last saw h[illegible] alive on Oct 5 1946

Immediate cause of death — Duration

Carcinoma of
Due to left Lung
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H J Lankart M. D.
Address 100 N. Milton Date signed 10/7/46

X

G44391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G44391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 St. Paul st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Francis Rooney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emily Stoner Rooney
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 12/19/1900

8. AGE: Years	Months	Days	If less than one day
45	9	17	hr. min.

9. Birthplace Harford Co - Md
(Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Maryland Drydocks

FATHER
12. Name James Rooney
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Kearney
15. Birthplace Maryland

16 (a) Informant Mrs. Emily Stoner Rooney
(b) Address 1703 St Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. P. Evans & Son
(b) Address 118 W. Mt. Royal St.

19 (a) OCT 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-1946 at 10 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 10-7-46

VS 181

Please write the causes of death clearly and legibly.

G44392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 837

G44392 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Sterling st
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Sterling st. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles McClain Wright.

3 (b) If veteran, name war I	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19-1896

8. AGE: Years	Months	Days	If less than one day
50	5	17	hr. min.

9. Birthplace Arnold Md. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name John Wright
13. Birthplace Annapolis Co Md.

MOTHER
14. Maiden Name Ella?
15. Birthplace Annapolis Co Md.

16 (a) Informant Bertha Wright
(b) Address 1016 Sterling St.

17 (a) L (Burial, cremation, or removal) (b) Date thereof 10 10 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md.

18 (a) Funeral director J. Preston Tenney
(b) Address 514 Madison st.

10 8 1946 (Date rec'd by local reg.) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6- 1946 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4- 1942 to 10-6- 1946 and that I last saw h(er) alive on 10-6- 1946.

Immediate cause of death Coronary Thrombosis.

Due to Arteriosclerosis Hypertension

Due to Senility.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank F. Harman M.D.
Address 2340 Madison Ave Date signed 10-8-46

VS 3

Harman X

G44393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G44393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Edmondson Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Young

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1867

8. AGE: Years	Months	Days	If less than one day
78	10	13	hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Harris

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Eliza Harris

15. Birthplace Pennsylvania

16 (a) Informant Norwood Poulson

(b) Address 1708 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. A. Holland

(b) Address 1611 Druid Hill Ave.

19 (a) (Date rec'd by registrar) OCT 8 - 1945 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1945 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21/45 to 10/6/45; and that I last saw h alive on 10/4/45

Immediate cause of death: (a) Arterio Sclerosis (b) Decubitus

Due to: Hard Work

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Lee Edwards M.D.

Address 1611 Druid Hill Ave. Date 10/7/45

VS 150

G44394

501295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

G44394
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Gary. (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 718 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virgil Braxton.

3 (b) If veteran, name war

3 (c) Social Security Account No. 232-12-6054

4. Sex: Male. 5. Color or race: Colored. 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jessie May.

6 (c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): 12-24-06.

8. AGE: Years: 39. Months: 9. Days: 12. If less than one day: hr. min.

9. Birthplace: Va (Town, county, and state)

10. Usual Occupation: Miner

11. Industry or business

12. Name: James Braxton

13. Birthplace: Va.

14. Maiden Name: Verdie Bhoate

15. Birthplace: Va

16 (a) Informant: Jessie Mae Braxton

(b) Address: Box 718 - Gary, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 8, 1946 (month) (day) (year)

(c) Cemetery or crematory: Family Lot

Location: Gary, W. Va

18 (a) Funeral director: Mrs. Cox, W. Holland

(b) Address: 163 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION D

20. DATE OF DEATH Oct. 6, 1946 at 1155 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1946 to Oct. 6 1946 and that I last saw him alive on Oct. 6 1946.

	Duration
Immediate cause of death: Post-operative hemorrhage.	10 hours
Due to: Suprasellar tumor of brain.	
Due to:	
Other Conditions: Purulent Pericarditis	

(Include pregnancy within 3 months of death)

Date of operation: Sept 23, 1946

Major findings of operation: Suprasellar tumor.

Findings of autopsy: Not autopsied in Texas.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Arthur M. Lewis, M. D.

Address: Johns Hopkins Hosp. Date signed: 10/7/46

VS 150

G44395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 E. 26th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: HUGH A. HARTMAN

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 215-03-3588

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel P. Hartman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1891

8. AGE: Years 54 | Months 9 10 | Days 23 | If less than one day hr. min.

9. Birthplace: Boston, Mass. (Town, county, and state)

10. Usual Occupation: Chief Shipping Clerk

11. Industry or business: Carrolton Spring Dis.

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Ethel P. Hartman
(b) Address: 328 E. 26th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10, 1946 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore, Md.

18 (a) Funeral director: Durward Q. Covington
(b) Address: 21 W. 25th St.

19 Date rec'd by reg'r: OCT 8 - 1946 Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7. 1946. 4.40 a M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture pelvis; Peritonitis; Rt. renal lithiasis; Rt. pyonephrosis; right renal infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/3

(a) Date of injury 9-28-46 at 4.40 a. M.
(b) Where did injury occur? 27th & Barkley St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pediastrian- stuck by auto

23. Signature: George L. Merrill M.D. Medical Examiner.
Date signed: 10-7-46

X

Correct age in completely, if unknown, physicians please write the

G44396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County none
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 708 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Lawson Whitney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary Orita Whitney | (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1887

8. AGE: Years 59 | Months 0 | Days 4 | If less than one day: hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)

10. Usual Occupation Haberdasher

11. Industry or business

FATHER 12. Name Henry Whitney
13. Birthplace Maryland ?

MOTHER 14. Maiden Name Margaret Christ
15. Birthplace Maryland ?

16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Ave

18 (a) Funeral director John B. Mitchell & Son
(b) Address 1906 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

Oct 8 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1946 at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1946 to Oct. 7 1946 and that I last saw h[illegible] alive on Oct. 7 1946.

Immediate cause of death	Duration
Cerebral Embolus	4 hrs.
Due to Arteriosclerotic Heart Disease	3 yrs.
Due to	
Other Conditions Cardiac Decompensation (Include pregnancy within 3 months of death)	10 days

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 10/7/46

G44397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G44397 Registered No.

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Ward or address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town, limits write RURAL and give county)
(d) Street No. 104 W University Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen B. Lowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Jean Walters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19??

8. AGE: Years	Months	Days	If less than one day
47?	2		hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John W. Lowe
13. Birthplace New Freedom, Pa.

MOTHER
14. Maiden Name Elizabeth Merritt
15. Birthplace Md.

16 (a) Informant Mr. John W. Lowe Jr.
(b) Address 6407 Ridgewood Ave. Chevy Chase, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1946 (month) (day) (year)

(c) Cemetery or crematory Cold Spring
Location Cape May, N. J.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Oct 9 1946 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Oct 1946 at 7.15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Burn, third degree - severity fm parent of bodyarea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7 Oct 46 at 6 30 P.M.
(b) Where did injury occur? 104 W University Pkwy
(c) Did injury occur at home, on farm, industrial place, in public place? Apartment House (While at work?) No
(d) Means of injury Bed clothes caught afire

23. Signature William F. Kelly M.D.
Medical Examiner.
Date signed 7 Oct 46

BC# G44398 9134099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V119a

Registered No. G44398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3801 Mt. Pleasant Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Mt. Pleasant Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin J. Rosengarn ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1945

8. AGE: Years	Months	Days	If less than one day
1	0	0	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Chas. Rosengarn
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ethel May Wise
15. Birthplace Balto. Md.

16 (a) Informant Chas Rosengarn
(b) Address 3801 Mt. Pleasant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1946 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 - 1946 to Oct 16 1946 and that I last saw him alive on Oct 16 1946,

Immediate cause of death: Auto - Intoxication — Duration
or
Due to Intestinal Poison imp.
or
Due to Gastro Enteritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen S. Burham, M.D.
Address 3137 E. Balto Date signed 10-8-46

X 46

G44399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G44399

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 S. PORT ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S. PORT ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JAKUBIK (JAKUBIK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife MARY DUDEK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1886

8. AGE: Years 60 Months 7 Days 17 If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER 12. Name UNKNOWN

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant HELEN CORTESE

(b) Address 713 S. PORT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/9/1946 (month) (day) (year)

(c) Cemetery or ~~cemetery~~ HOLY ROSARY

Location GERMAN HILL RD

18 (a) Funeral director John Jr. Thyler

(b) Address 401 S. Chester St.

19 (a) (Date received by registrar) (b) Registrar, M.D.

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1946, to Oct 5 1946 and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration 2 Days

Due to Arteriosclerosis — Subsequent

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo F. Schlack M.D.

Address 126 S. Port St Date signed Oct 7 1946

PKAR X

G44400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44400 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 5 mo 10
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Hughes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mary Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1858

8. AGE: Years	Months	Days	If less than one day
88	1	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Engineer on boat
11. Industry or business

FATHER
12. Name John Hughes
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Timoney
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Stow City
17 (a) Burial (b) Date thereof Oct 9, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore
18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.
19 (a) Date received OCT 8 1946 (b) Registrar Williams M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7- 1946, at 3.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-1 1946, to Oct 7- 1946, and that I last saw h[illegible] alive on Oct-5 1946.

Immediate cause of death

	Duration
Edema Lungs	1 day
Due to Chronic myocarditis	3 yrs
Due to	
Other Conditions Arterio-Sclerosis	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Av Date signed 10/5/46

Correct 88 yrs especially important — 10 years

G44401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G4410

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE.
(c) City or town GOWANS, BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 CAMPBELL LANE. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET ANNA FULD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-38

8. AGE: Years 8 Months 0 Days 26 If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER: 12. Name STUART G. FULD.
13. Birthplace BALTIMORE, MD.

MOTHER: 14. Maiden Name HELEN POWELL.
15. Birthplace VIRGINIA

16 (a) Informant STUART G. FULD.
(b) Address BALTIMORE, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10-46 (Month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (Date received by registrar) (By) Huntington Williams

VS 10M OCT 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 7 1946, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 30 1946, to OCT. 7 1946, and that I last saw HER alive on OCT. 7, 1946.

Immediate cause of death

	Duration
ACUTE LYMPHOID LEUKEMIA	1 Mon.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy ACUTE LYMPHOID LEUKEMIA

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent J. Penner M. D.
Address Union Memorial Date signed 7 Oct 46

Penner ×

G44402 G44402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4019 Carlisle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 Carlisle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Sezzin Z

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Abraham Zerwitz
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Melchesky
15. Birthplace Russia

16 (a) Informant Max Sezzin
(b) Address 4019 Carlisle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 OCT 8 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1946 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1946 to Oct. 8 1946, and that I last saw alive on Oct. 8 1946

Immediate cause of death: General Carcinomatosis — Duration 5 mo.

Due to Carcinoma of the breast. — 17 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 30, 1945

Major findings of operation: Ca. of Breast.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Silver M. D.
Address Temple Gardens Apts Date signed Oct. 8, 1946

G44403 — BALTIMORE CITY HEALTH DEPARTMENT — G44403

CERTIFICATE OF DEATH v 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 S. Clinton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 S. Clinton st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard D. Keagh

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-7276

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary C. Keagh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1880

8. AGE: Years	Months	Days	If less than one day
66	6	26	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Tool Designer
11. Industry or business Lul Products Co.

FATHER — 12. Name Lorraine Mc. Keagh
13. Birthplace Md.

MOTHER — 14. Maiden Name Grace J. Coates
15. Birthplace W. Va.

16 (a) Informant Emma K. Knox
(b) Address 3705 Cranston Ave

17 (a) Burial (b) Date thereof 10/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 9 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1946 at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1946, to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Coronary occlusion — Duration: Sudden death

Due to:

Due to Coronary Thrombosis — 4 years

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. Davidow M. D.
Address 3218 Eastern Ave Date signed 10-8-46

VS 150

G44404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1119a

G44404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frd. Co
(c) City or town Thurmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Otto Beall Jr.
3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-26-46.
8. AGE: Years | Months: 1 | Days: 17 | If less than one day: hr. min.
9. Birthplace Gettysburg Pa (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Roland Beall
13. Birthplace Md

MOTHER
14. Maiden Name Kathryn Sayler
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-1946 (month) (day) (year)
(c) Cemetery or Crematory Graceham Cem
Location Graceham Md
18 (a) Funeral director M L Creager Sons
(b) Address Thurmont Md
19 (a) (Date rec'd by registrar) (b) Registrar

Oct 9 1946 Huntington Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1946 at 7:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1946 to Oct. 8 1946, and that I last saw him alive on Oct. 8 1946.

Immediate cause of death: DIARRHOEA OF THE NEWBORN — Duration: 19 days
Due to
Due to
Other Conditions PREMATURITY — LIFE
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul H. Harbaugh M. D.
Address JOHNS HOPKINS HOSP Date signed 10/8/46

G44405 G44405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1316

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Myrtle Ave
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Morris

3 (b) If veteran, name war V | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/[illegible]4

8. AGE: Years	Months	Days	If less than one day
62	6	22	hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name James Morris
13. Birthplace Va.

MOTHER
14. Maiden Name Judy?
15. Birthplace Va

16 (a) Informant Bessie Morris
(b) Address 1315 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location C. A. Co.

18 (a) Funeral director Sam'l. M. Chase & Son
(b) Address 638 N. Schroeder St.

OCT 9 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 19 46, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 46 to 10/8 46, and that I last saw h alive on 19

Immediate cause of death
Cer. Hemorrhage
Due to Nephritis
Due to Uremia
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. Hurtt M. D.
Address 94 Dallas St. Date signed 10-8-46

G44406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G44406

Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gen'l Balto Dem Hosp
(c) Hospital or institution: Cayzer + Dukeland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2844 Huntingdon (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry D. Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-9575

4. Sex M | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Bertha L. Brown

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1871

8. AGE: Years	Months	Days	If less than one day
75	-	28	hr. min.

9. Birthplace Maryland. (Town, county and state)

10. Usual Occupation Retired (Stationary Engineer)

11. Industry or business Women's Hosp.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Bertha L. Brown.
(b) Address 2844 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10/46 (month) (day) (year)
(c) Cemetery or crematory Pleasant Grove, Location Boring, Md.

18 (a) Funeral director Edmonson Bros
(b) Address 3615-17 Edmondson Ave

19 (a) OCT 9 - 1946 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1946, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1946, to 7 Oct 1946 and that I last saw h[im] alive on 7 Oct 1946

Immediate cause of death Renal Insufficiency — Duration

Due to Hydronephrosis — Duration

Due to Arteriosclerotic C.V. Renal Dis — Duration

Other Conditions Bronchopneumonia — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester G. Hall, M. D.
Address Gen'l Balto Dem Hosp Date signed 10/9/46

VS 150

G44407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G44407

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 Frances St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-3
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 Frances at (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES RICHARDSON

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) - - 1893

8. AGE: Years	Months	Days	If less than one day
53	1	1	hr. min.

9. Birthplace S. C. (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Richardson
13. Birthplace S.C.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace S.C.

16 (a) Informant Ernest Richardson
(b) Address 850 Pierce St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10. 11. 46 (month) (day) (year)
(c) Cemetery or crematory WINNSBORO CEM
Location WINNSBORO · S. CAROLINA

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

OCT 9 - 1946 (Date received by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1946, at 3:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Oct 7 1946, and that I last saw him alive on Oct 7 1946.

Immediate cause of death	Duration
Cardiac Vascular renal disease	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts
Address 515 Lexington Date signed 10/8/46 M. D.

G44408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44408 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2428 Eutaw Place (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Detering Stauch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Ernest Dustayer
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) 3/9/1859

8. AGE: Years	Months	Days	If less than one day
70	6	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation H. Wife
11. Industry or business

FATHER 12. Name Fred Detering
13. Birthplace Germany

MOTHER 14. Maiden Name Pauline Ambrust
15. Birthplace Germany

16 (a) Informant Mrs. Mildred Emmert
(b) Address 2428 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/46 (month) (day) (year)
(c) Cemetery or crematory Catherdral
Location Old Frederick Road

18 (a) Funeral director L. J. Daley & Sons
(b) Address 1811 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1946, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 19 to Oct 7 1946, and that I last saw h alive on 19

Immediate cause of death myocardial failure — Duration 4 yr

Due to Hypertension — 9 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22 If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify kind of place)
(e) Means of injury

23. Signature Emmert Litzelove
Address 1720 Eutaw Pl Date signed Oct 8/46

DEC 9 - 1946

(over)

G44409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44409 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town [redacted] Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Melrose Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Charlotte Wigner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Wh	Wid

6 (b) Name of husband or wife [illegible] Wigner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1857

8. AGE: Years	Months	Days	If less than one day
79 (3)	4	27	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Emil Kolbe
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Betz
15. Birthplace

16 (a) Informant James Kolbe (nephew)
(b) Address Owings Mills Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-46 (Month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Frank H. Mayfield
(b) Address Pikesville, Md

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 9 - 1946 Hunter for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 19 46, at 10 12 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 19 46 to 10-7 19 46, and that I last saw her alive on 10-7 19 46.

Immediate cause of death	Duration
Myocardial failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address U. Md. Date signed 10-7-46

X

G44450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G44450 Registered No.

Please write the causes of death clearly and legibly. Physicians: please state the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 N. 34th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. 34th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah R. Snyder

3 (b) If veteran, name war —

(c) Social Security Account No. 219-20-8668

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose B. Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24-1884

8. AGE: Years	Months	Days	If less than one day
62 62	6	13	hr. min.

9. Birthplace Martinsburg W. Virginia (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or Business

FATHER
12. Name John Wesley Snyder
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah Jane Gordon
15. Birthplace West Virginia

16 (a) Informant Mrs. Rose B. Snyder
(b) Address 827 N. 34th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9-1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 1421 Falls Road

19 (a) OCT 9 - 1946 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-1946 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 10-7-46

VS 151

G44411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44411 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Dellwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 -
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Dellwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Urbin Whitney Grimm

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-6662

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cora May Grimm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16-1877

8. AGE: Years 68 | Months 9 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Maryland (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William C. Grimm
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Fare
15. Birthplace Maryland

16 (a) Informant Mrs. Cora May Grimm
(b) Address 1212 Dellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11-1946 (month) (day) (year)
(c) Cemetery or crematory New Market
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

19 (a) OCT 9 - 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8- 1946, at 12 N. A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to Oct 8 1946 and that I last saw h[illegible] alive on Oct 8 1946

Immediate cause of death: Coronary Thrombosis — Duration 24 hrs

Due to Arteriosclerotic CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J. Linnane MD M. D.
Address 3711 Falls Rd Date signed 10-8-46

VS 150

X

G44112 G44112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 124 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Vincent St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Daniel Wilkins

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1901

8. AGE: Years	Months	Days	If less than one day
45	2	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name JACOB WILKINS
13. Birthplace EASTERN SHORE MD

MOTHER
14. Maiden Name MAMIE MITCHELL
15. Birthplace EASTERN SHORE MD

16 (a) Informant Mrs Mary Brown
(b) Address 1512 Millman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 66 West Bare St

OCT Date received 1946 (b) Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1946, at 1.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21-1946 to 10-8-1946, and that I last saw him alive on Oct 7 1946.

Immediate cause of death	Duration
Pulmonary Congestion	
Due to Cirrhosis of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles T. Washington M.D.
Address 8 L Rayburn Date signed 10-8-46

Huntington Williams, Md

X

G44413

WALBURGA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44413 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N. Becker Ave., Balt
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walburga Lorber

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-7898

4. Sex	5. Color or race	6 (a) Single, married, widowed, or ~~divorced~~
F	W	S

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1887

8. AGE: Years	Months	Days	If less than one day
58	09	24	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Lorber
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Mero
15. Birthplace Baltimore

16 (a) Informant James Lorber
(b) Address 1213 N. Potomac St. Balti

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10 - 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Josh D. Stein & Sons
(b) Address 300 N. Kentucky Ave

19 (a) OCT 9 - 1946 (Date filed by registrar) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1946, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7, 9:30 1946 to Oct 7, 10:30 1946 and that I last saw her alive on Oct 7 1946.

Immediate cause of death - Resp. Failure	Duration
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James T. Mercer Jr. M. D.
Address Date signed

VS 150

X

G14414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G14414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1376 Calhoun Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1376 Calhoun Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. GRAY ✓

3 (b) If veteran, name war: W.W #1
3 (c) Social Security Account No. unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Sep

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/1894

8. AGE: Years	Months	Days	If less than one day
51 52	10		hr. min.

9. Birthplace Balto. Md. (Town, county, state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Charles H. Gray
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Knight
15. Birthplace Durham N.C.

16 (a) Informant Wilford H. Gray
(b) Address 1401 Fayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat.
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Freetman St

19 (a) (Date received by registrar) 1946 (b) Huntington Woollett Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1946 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia, right upper lung
Due to
Other Conditions Syphilitic aortitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/8/46

G44415 Fullwood

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G44415 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1514 Division st
(b) Street address ~~Hospital~~
(c) Hospital or institution: Provident 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Abt 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 W. Saratoga (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Gross Fullwood
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race N | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Clyde Fullwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/1908

8. AGE: Years	Months	Days	If less than one day
38	2	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name John Hyle
13. Birthplace md

MOTHER
14. Maiden Name Nellie Horsey
15. Birthplace md

16 (a) Informant Della Jackson
(b) Address 1624 W Saratoga st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calivary
Location Mt
18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Presstman st
19 (a) (Date received by registrar) (b) Registrar
OCT 9 1946
Huntington Williams M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1946, at 5:07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1946 to 10/6 1946 and that I last saw h[illegible] alive on 10/6 1946.

Immediate cause of death Uremia — Duration

Due to Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Malignant Nephrosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles H. Wagner M. D.
Address 8 E. Kinsley Date signed 10-8-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. 644116

644116

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs. 25 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 878 W. Fayette St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell Booker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 24, 1933

8. AGE: Years	Months	Days	If less than one day
13	5	10	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER
12. Name Russell Booker, Sr.
13. Birthplace Md

MOTHER
14. Maiden Name Anna Dorsey
15. Birthplace Md.

16 (a) Informant Russell Booker
(b) Address 878 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Freeman St

19 (a) OCT 9 - 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1946, at 1:05 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage
Laceration of the brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 16-2
(a) Date of injury 10-7-46 at 10:35 P. M.
(b) Where did injury occur? Mosher + Stricker Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by auto.

23. Signature Howard J. Mahoney M.D.
Medical Examiner.
Date signed 10-8-46

VS 191

Clinic DC-B60484
G11117

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G11117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 School St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Jordon.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male
5. Color or race negro
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-7-46
8. AGE: Years | Months | Days 15 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name William Burgess
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Jordon
15. Birthplace Boston Mass

16 (a) Informant Mrs. Helen Jordon
(b) Address 612 School St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. A. Kelson
(b) Address 353 Preastman st
19 (a) (Signature of registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-1946; at 4:25 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9-22-1946, to 10-7-1946, and that I last saw him alive on 10-7-1946.
Immediate cause of death Prematurity — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. Louise Jones
Address 1400 Druid Hill Ave Date signed 10/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams Md

G4418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G4418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 S. Glover st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 55 —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town, write RURAL and give town)
(d) Street No. 813 S. Glover Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Teodozia Jakubowski

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Kitchens Cashier

11. Industry or business Canning

FATHER
12. Name W. Pizut
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Casimir Jakubowski
(b) Address 815 S. Glover Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10 46 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director Marge E. Fialkowski
(b) Address 1000 S. Kenwood Ave

19 (Filed) OCT 9 - 1946 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1946 at 930 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946, to Oct 7 1946 and that I last saw h[illegible] alive on Oct 6 1946

Immediate cause of death

	Duration
Hypertension Cardio-Vascular Renal a cerebral Hemorrhage	Several
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Casimir Jakubowski M. D.
Address 2579 Eastern Ave Date signed

VS 150

G34419 BC# 54913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G34419

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Forsyth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Kernan

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1946

8. AGE: Years | Months | Days 13 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Eugene J Kernan
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine A Brennan
15. Birthplace Ireland

16 (a) Informant Eugene J Kernan
(b) Address 1513 Forsyth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director J Bernard Kelly
(b) Address 2334 N Charles St

19 (a) (Date received by registrar) OCT 9 1946 Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1946, at 4 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1946 to 10-9 1946 and that I last saw her alive on 10-9 1946.

Immediate cause of death: Respiratory failure — Duration
Due to Cerebral birth injury
Due to
Other Conditions Osteomyelitis of mandible.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kay L. Markley M.D.
Address Bon Secours Hosp. Date signed 10-9-46

VS 150

G44420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

G44420

File No. 105126

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2-Months & 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Payson St (North)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Buchwald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Louise Buchwald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8th 1883

8. AGE: Years	Months	Days	If less than one day
63	8	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation BARTENDER
11. Industry or business SALOONKEEPER

FATHER
12. Name Frederick Buchwald
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Koehler (D
15. Birthplace Germany

16 (a) Informant GEO. M. BUCHWALD
(b) Address 2927 BELMONT AVE

17 (a) BURIAL (b) Date thereof 10/OCT. 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN CEMETERY

18 (a) Funeral director F. D. WIEBERT & SON
(b) Address 308 EUTAW PLACE

19 (a) OCT 9 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH October 7th 19 46, at 5.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1946 to Oct 7 19 46, and that I last saw him alive on Oct 7th 19 46.

Immediate cause of death: Carcinoma of Lung — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Autopsy Carcinoma
Major findings of operation: of Lung Metastasis
of autopsy Both plura & kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Robinson Jr. M.D.
Address Balt. City Hosp. Date signed 10-7-46

VS 150

The G44121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G44121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts.
(c) Hospital or institution Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.-md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Idelle Bryarly Fricker

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John A. Fricker

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 22 1879

8. AGE: Years	Months	Days	If less than one day
67	6	16	hr. min.

9. Birthplace Balto.-Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph F. McBee

13. Birthplace Md.

MOTHER 14. Maiden Name Ariel K. Lee

15. Birthplace Md.

16 (a) Informant John A. Fricker (husband)

(b) Address 3333 N. Charles St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. MOWEN SUC.) 100 W. AUSTIN AVENUE

19 (c) Filed OCT 9 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1946, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1946 to 10/8 1946, and that I last saw HER alive on 10/8 1946.

Immediate cause of death PULMONARY EDEMA AND TERMINAL BRONCHOPNEUMONIA — Duration 2 DAYS

Due to PARALYSIS OF VOCAL CORDS & LOSS OF COUGH REFLEX

Due to PROBABLE BULBAR ARTERIOSCLEROSIS AND THROMBOSIS

Other Conditions CARCINOMA OF CERVIX

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M.D.

Address Md. Gen. Hosp. Date signed 10/8/46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G44422 **CERTIFICATE OF DEATH** 83a Registered G44422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Light St.
(c) Hospital or institution:
24+
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. R. Lowe.

3 (b) If veteran, name war —
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Addie M. Wally
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1882

8. AGE: Years	Months	Days	If less than one day
64	7	—	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Buck Layer
11. Industry or business Const.

FATHER 12. Name James
13. Birthplace Md.

MOTHER 14. Maiden Name Georgianna ?
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1601 Light St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-10-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto. Md.

18 (a) Funeral director H. C. Lindsay
(b) Address 30 E. Fort Ave.

(c) Filed OCT 9 - 1946 (Date received by registrar) (d) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1946 to Oct 7 1946.
and that I last saw h[illegible] alive on Oct 6 1946

Immediate cause of death: Oedema of Lungs — Duration 24 hrs.
Due to: Cerebral Hemmorhage, — 3 wks.
Due to: (Left Hemiplegia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Lutkenhaus M.D.
Address 708 E North Ave Date signed 10/5/46

VS 150

G44423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G44423

Registered No.

499690 92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 William St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marian Raimondi

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Fromcia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-06.

8. AGE: Years	Months	Days	If less than one day
40	7	15	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Sortino
13. Birthplace Italy

MOTHER 14. Maiden Name Joh. Raimondi
15. Birthplace Italy

16 (a) Informant Reynolds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Location Belair Rd. Baltimore
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Monroe St
19. (a) (Date rec'd by Registrar) (b) Huntington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1946, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1946, to Oct. 8 1946 and that I last saw h alive on Oct. 5 1946

Immediate cause of death Respiratory Failure — Duration

Due to Chronic Rheumatic Heart disease
= dyspnea & cardiac decompensation

Due to Mitral Stenosis, organized pericarditis
& Chronic congestive heart failure

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice B. Rowland M. D.
Address J Hk H Date signed Oct 46

VS 130

G44424 BALTIMORE CITY HEALTH DEPARTMENT G44424
CERTIFICATE OF DEATH 48 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2722 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Teller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Frank Teller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1874

8. AGE: Years 72 Months 5 Days 25 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Schuder
13. Birthplace Germany

MOTHER
14. Maiden Name Veronica
15. Birthplace Germany

16 (a) Informant Francis E Hildebrand
(b) Address 2722 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gorsuch Lorman Hill Rd

18 (a) Funeral director John E Horan
(b) Address 3600 E Baltimore St

19 (a) [illegible] Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1946, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1945 to Oct 7 1946 and that I last saw h alive on Oct 7 1946

	Duration
Immediate cause of death: Pulmonary Edema	
Due to: 2 days	
Due to: Pneumonia to Concussion of Brain	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place) None
(e) Means of injury None

23. Signature R J Kelly
Address 100 N Linwood Ave Date signed Oct 8 46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

G44425
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Gordon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Ashby Putnam

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Putnam

6 (b) Name of husband or wife Mrs. Emma Baldwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/4/1880

8. AGE: Years	Months	Days	If less than one day
66	1	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Banker
11. Industry or business

FATHER
12. Name Mr. William F. Putnam
13. Birthplace Virginia

MOTHER
14. Maiden Name Ford Virginia Andrews
15. Birthplace Virginia

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Bel Air, Harford Co, Md Rural

18 (a) Funeral director Dean & Foster
(b) Address Bel Air, Md

19 D.T. (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9th 1946, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Oct 9 1946 and that I last saw h.i.m. alive on Oct 9 1946.

Immediate cause of death Toxemia from Pulmonary infarction, bronchopneumonia & Fibrinous pericarditis — Duration

Due to Ca of the Rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-19-46
Major findings of operation: Ca rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address A.M.A. Date signed 10-9-46

X

G44426 BC# G34112 **BALTIMORE CITY HEALTH DEPARTMENT** ✓ G44426 **Registered No.**

CERTIFICATE OF DEATH 180

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1757 Jefferson Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Ann DENTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/45

8. AGE:	Years	Months	Days	If less than one day
	1	11	26	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name William Denton
13. Birthplace Chester, S. C.

MOTHER
14. Maiden Name Asylee V. Williams
15. Birthplace Fayetteville N. C.

16 (a) Informant William Denton
(b) Address 1757 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave

19 (a) (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1946, at 4:15 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Accidental burns.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-7-46 at 7:15 A. M. 6/5
(b) Where did injury occur? 1757 Jefferson Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Upset of stove

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 10/8/46

39396 G44127

BALTIMORE CITY HEALTH DEPARTMENT V G44127
Registered No.

CERTIFICATE OF DEATH 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Payne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-17-1901

8. AGE: Years	Months	Days	If less than one day
45 -	11	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie Roman
15. Birthplace Virginia

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Putty Hill MD

18 (a) Funeral director Elroy Davidson
(b) Address 1000 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1946, at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31 1946, to 10-8 1946, and that I last saw h alive on 10-8 1946.

Immediate cause of death: Pulmonary Hemorrhage — Duration
Due to: Tuberculosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 10/4/46
Major findings of operation: Tuberculosis of upper middle lobes of
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Duncan
Address JHH Date signed 10/8/46

VS 150

G44128 — BALTIMORE CITY HEALTH DEPARTMENT — G44128

CERTIFICATE OF DEATH 195E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324- E. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LORRAINE REEVES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace Pitt Co. N. C. (Town, county, and state)

10. Usual Occupation Defense Worker

11. Industry or business

FATHER
12. Name Grant Hardy
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth Cooper
15. Birthplace N. C

16 (a) Informant Walter Hardy
(b) Address 263 N. Bethel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/46 (month) (day) (year)
(c) Cemetery or crematory
Location Pitt County, N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1946 at 4 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Comp. comminuted fract. of skull, Laceration of brain, Intracranial hemorrhage, and lacerations of scalp

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 5-1

(a) Date of injury 10-6-46 at 2.30 A.M.
(b) Where did injury occur? Mulligan & Lewis St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pediastrian-struck by unknown

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 10-7-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58E

Registered No. G44429

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road & Herring Run
(c) Hospital or institution: Sydenham Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kathleen Taylor ✓

3 (b) If veteran, name war ~

3 (c) Social Security Account No. ~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 Dec, '33

8. AGE: Years	Months	Days	If less than one day
7	10	2	hr. min.

9. Birthplace Baltimore, Baltimore Co, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Richey W. Taylor

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Katherine Hardy

15. Birthplace Baltimore

16 (a) Informant Mr Richard W. Taylor

(b) Address 217 N. High Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem

Location 3801 Frederick Rd.

18 (a) Funeral director John J Gorman & Son

(b) Address 901-03 Hollins St.

19 (a) OCT 9 - 1946 (Date rec'd by registrar) Lurington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 OCTOBER 1946 at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1946, to 10-9 1946 and that I last saw h 22 alive on 10-9 1946.

Immediate cause of death Myocardial failure. — Duration 50 days

Due to Rheumatic fever, acute.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myron D. Green M.D.
Address Sydenham Hosp Date signed Oct 9, '46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

G44430 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts
(c) Hospital or institution: Bon Secour Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence C. Della

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Louise C. Bruce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21st 1896

8. AGE: Years	Months	Days	If less than one day
50	5	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Life Owner
11. Industry or business Self

FATHER
12. Name John Della
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Martin
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Louise C. Della
(b) Address 925 Washington Blvd

17 (a) burial (b) Date thereof 10/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-07 Hollins St

19 (a) (Date received by registrar) (b) OCT 9 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1946, at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3/ 1946 to 10/8 1946 and that I last saw h in alive on 10/8 1946

Immediate cause of death	Duration
Cardiac Failure	15 min
Due to Operative Shock	1 hour
Due to	
Other Conditions Calculi Pancreas Diabetis Mellitus	Unknown

(Include pregnancy within 3 months of death)

Date of operation 10/8/46
Major findings of operation Pancreatic Calculi
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Catherine E. Lyons M. D.
Address Bon Secours Hosp Date signed 10/9/46

VS 150

G14431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G14431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 D
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Mitchell

3 (b) If veteran, name war

3 (c) Social Security No. 220-05-5231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Cassie Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace N. C.

MOTHER
14. Maiden Name unknown
15. Birthplace N. C.

16 (a) Informant Cassie Mitchell
(b) Address 422 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem
Location Hail Thorpe Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 9 N. Mount St

19 OCT 9 1946 (Date Rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1946, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1946 to 10/8 1946, and that I last saw h[illegible] alive on 10/8 1946.

Immediate cause of death	Duration
Congestive Heart Failure	3 weeks
Due to Pneumonia	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Hutchins, C
Address 426 N. Johns Date signed 10/9/46

G44432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Beechdale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Beechdale Road
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Charles G. Thurston

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1884

8. AGE: Years	Months	Days	If less than one day
62	0	2	-- hr. -- min.

9. Birthplace Mathews, Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Thurston
13. Birthplace Mathews, Virginia

MOTHER
14. Maiden Name Lessie Marchant
15. Birthplace Mathews, Virginia

16 (a) Informant Mrs. Susie M. Martenet
(b) Address 110 Beechdale Road

17 (a) Burial (b) Date thereof 10/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Family
Location Mathews, Virginia

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) ------- (b) -------
(Date rec'd by registrar) Registrar

VS 10 OCT 9 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1946, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Oct 1946 and that I last saw ~~him~~ her alive on 9 Oct 1946

Immediate cause of death: Arteriosclerotic Cardio-Vascular disease — Duration

Due to -------

Due to -------

Other Conditions -------

(Include pregnancy within 3 months of death)

Date of operation -------

Major findings of operation: -------

of autopsy: -------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -------
(b) Date of occurrence ------- at ------- M
(c) Where did injury occur? -------
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ------- While at work?
(Specify type of place)
(e) Means of injury -------

23. Signature William G. Thurston M.D.
Address 5006 Roland Ave Date signed 9 Oct 46

G44133 P.L. g-58472

BALTIMORE CITY HEALTH DEPARTMENT

TN. 104668 **CERTIFICATE OF DEATH** 15-E Registered No. G44133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Girl ~~Bachtold~~ Dashiell (Delores)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 20th 1946

8. AGE: Years | Months | Days: 16 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Earl M. ~~Bachtold~~ Dashiell
13. Birthplace ?

MOTHER 14. Maiden Name Delores Holcomb
15. Birthplace Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof Oct 8/1946 (month) (day) (year)
(c) ~~Crematory~~ crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 Date received by Local Registrar OCT 10 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 5th 1946 at 5.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1946 to Oct 5 1946 and that I last saw her alive on Oct 5 1946.

Immediate cause of death: Circulatory failure — Duration: 2 da

Due to Congenital mitral stenosis + insufficiency and congenital partial dextrocardia of the thoracic aorta. — Duration: life

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: —

of autopsy: same as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp Date signed Oct 8 '46

VS 150

(over)

G44434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 157E

Registered No. G44434

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami (If outside city or town limits, write RURAL and give town)
(d) Street No. 162 N. East 107th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F. Graves Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-43

8. AGE: Years	Months	Days	If less than one day
2	11	29	hr. min.

9. Birthplace Fla (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Graves

13. Birthplace N.Y.

MOTHER 14. Maiden Name Ellen ?

15. Birthplace Fla

16 (a) Informant Relative

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10/46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn, Location Miami Fla.

18 (a) Funeral director John C. Mitchell Hos.

(b) Address 1900 Eutaw Place

19 OCT 10 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1946 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1946 to Oct 9 1946 and that I last saw he alive on Oct 9 1946.

Immediate cause of death: Cerebral Thrombosis — Duration 1 d.

Due to: Operation for

Due to: Patent Ductus

Other Conditions: Arteriosus. — Duration life

(Include pregnancy within 3 months of death)

Date of operation 10-8-46

Major findings of operation: Patent Ductus

of autopsy: 11

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. S. Morrow M. D.

Address JHH Date signed 10-9-46

VS 150

X

G44135 CHK-104655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 B

G44135 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days 48- 7- 22-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Finecey

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-1809

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora Finecey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17-1898

8. AGE: Years	Months	Days	If less than one day
48	7	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Finecey
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Bail
15. Birthplace Maryland

16 (a) Informant Record-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 12 46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore
18 (a) Funeral director Philip Henry Sons
(b) Address 2034 Orleans St.
(Date received by Registrar) (c) Huntington Williams M.D.

OCT 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1946, at 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1946 to Oct. 9 1946 and that I last saw him alive on Oct. 9 1946.

Immediate cause of death: Circulatory failure — Duration

Due to Malaria Incomplete Treatment for Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumococcus Type I

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Doyle Valdon M. D.
Address PCH Date signed 10/9/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G11436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G11436 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 938 N. Castle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 938 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Schmidt ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Madaglena Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 - 1876

8. AGE: Years	Months	Days	If less than one day
70	4	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Madalena Schmidt
(b) Address 938 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 12 46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip H. Leury Sons
(b) Address 2024 Orleans St.
(c) (Date rec'd by registrar) OCT 10 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1946 to Oct 9 1946, and that I last saw h[illegible] alive on Sept. 30 1946.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Cerebral Hemorrhage	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Bull
Address 8-26 N Washington St Date signed Oct 9 1946

VS 150

G14437. HARRY L. GORDON X V G14437.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 da
(e) Length of stay in Baltimore (yrs., mos., or days) 68 da

2. USUAL RESIDENCE OF DECEASED:
(a) State — (b) County —
(c) City or town Wash DC.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5517 - 7th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Harry L. Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Jennie 6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 15 March 1898

8. AGE: Years	Months	Days	If less than one day
48	6	24	3 hr. 4 min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Painter

11. Industry or business

FATHER
12. Name Solomon Gordon
13. Birthplace Russia

MOTHER
14. Maiden Name Oda ?
15. Birthplace Russia

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Washington
Location District of Columbia

18 (a) Funeral director Earl L. Hess
(b) Address 715 Eight St.

19 OCT 10 1946 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1946 19 , at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 19 46 to 9 Oct 19 46, and that I last saw h[im] alive on 9 Oct 19 46

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Carcinoma of Sigmoid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5 Aug 1946
Major findings of operation: Carcinoma of sigmoid & metastasis to liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Fohlmeister
Address CH or H Date signed 9 Oct 46

VS 150

BG 44438 BC-H-55843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

Registered No. G44438

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1800~~ Mercy Hospital
(c) Hospital or institution: Saratoga & Calvert Sts.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 / 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 N Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Krajewski

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/9/46

8. AGE: Years	Months	Days	If less than one day
0	0	1	— hr. — min.

9. Birthplace Baltimore, Baltimore, Md. (Town, county, and state)
10. Usual Occupation (Newborn)
11. Industry or business —

FATHER
12. Name Walter J. Krajewski
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Genevieve Bonk Dammowicz
15. Birthplace Baltimore, Md.

16 (a) Informant —
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-46 (months) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Gerrman Hill Rd

18 (a) Funeral director John J Kuda
(b) Address 2059 Hudson St

19 OCT 10 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct., 1946, at 10:58 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Oct 1946 to 9 Oct. 1946, and that I last saw him alive on 9 Oct. 1946.

Immediate cause of death	Duration
Unknown	
Due to (Erythroblastic syndrome)	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E B Munson M. D.
Address Mercy Hosp., Balto. Md. Date signed 10/9/46

VS 150

G44139 BALTIMORE CITY HEALTH DEPARTMENT G44139

CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4110 White Avenue
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4110 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUELLA B. BROOKS

3 (b) If veteran, name war: -

3 (c) Social Security Account No.: -

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1886

8. AGE: Years 60 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name George W. Brooks
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sallie Eckhard
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Frank Cox
(b) Address 5112 Ardmore Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date filed (b) Huntington Williams, M.D.
OCT 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1946, at 2.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic heart disease
Pulmonary edema
Due to

Other Conditions Chronic cholecystitis and cholelithiasis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/9/46

VS 151

A serious error of omission or commission may subject the undertaker to a penalty. Be sure that the information given is correct and complete. Where exact data are unknown, approximate dates are acceptable. Items 1 to 15 must be answered. Every item should be answered; if unknown or if not applicable, write none. Space for cause of death must be filled. Even though the age is approximate, it is especially important. Physicians: please write the causes of death clearly and legibly.

G44140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1641 Warwick Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 Warwick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucian Minor King

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Elizabeth King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1883

8. AGE: Years	Months	Days	If less than one day
62	10	23	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Machinist (Retired)
11. Industry or business

FATHER
12. Name Lucian Minor King
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Henrietta Gibson
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Elizabeth King
(b) Address 1641 Warwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 10 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9- 1946 at 7 15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inq. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/9/46

X

FOR CORRECTIONS, WRITE ONE ADDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G34411 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4603 Pall Mall Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THERESA C. INGLIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	20	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Charles A. Inglis
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary D. Lowery
15. Birthplace Maryland

16 (a) Informant Mr. Charles A. Inglis
(b) Address 4201 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ~~OCT 10 1946~~ (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1946, at 12.45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Oct 9 1946, and that I last saw h[illegible] alive on Oct 9 1946.

Immediate cause of death	Duration
Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos D Burkart M. D.
Address 1803 Park Heights Ave Date signed 10/10/46

VS 150

G44112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G44112 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 Evesham Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Evesham Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST ANDREW KRENGEL

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Annie Gelletly Krengel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 18, 1864

8. AGE: Years	Months	Days	If less than one day
82	2	21	hr. min.

9. Birthplace: Richmond, Va. (Town, county, and state)
10. Usual Occupation: Storekeeper (Retired 16 Yrs.)
11. Industry or business: U. S. Industrial Alcohol Co.

FATHER
12. Name: John Krengel
13. Birthplace: Holland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Miss Ethel Annie Krengel
(b) Address: 412 Evesham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 10/10/46 (Date rec'd by Registrar) (b) Huntington Williams, M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1946 at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 46 to Oct 9 1946, and that I last saw h[illegible] alive on Oct. 9 1946.

Immediate cause of death	Duration
Bronchogenic Cancer & Lung.	1 year.
Due to \	
Due to \	
Other Conditions Senility.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. S. Chaffee, M.D.
Address 610 York Rd. Date signed Oct 12, 46

VS 150

G11413 G11413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1926

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Eastland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Eastland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles C. Travis

3 (b) If veteran, name war None

3 (c) Social Security Account No. 217-22-9618

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie Travis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1899

8. AGE: Years 47 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Louisa Co. Va. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business Theatre Md Dairy (Sealed Ct)

FATHER
12. Name Andrew Travis
13. Birthplace Va.

MOTHER
14. Maiden Name Sumpie —
15. Birthplace N.C.

16 (a) Informant Annie Travis
(b) Address 1317 Eastland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Robert L. Cromwell
(b) Address 1216 W. Caroline St

19 (a) OCT 10 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1946, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-19 1945 to Oct 7 1946, and that I last saw h alive on 10-5 1946.

Immediate cause of death (a) Cerebral Hemorrhage — Duration 11 hrs
Due to (b) Uremia — Duration 7 days
Due to (c) Chronic Nephritis — Duration 1 year
Due to (d) Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. K. Evans M. D.
Address 1222 E. Caroline Date signed 10-9-46

VS 100

G[illegible]1414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G[illegible]1111 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 N. Ann St.
(c) Hospital or institution: 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19yrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas A. Scott

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alma Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1881

8. AGE: Years 65 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Barber (Unemployed)

11. Industry or business

FATHER
12. Name Joseph Scott
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Thurson
15. Birthplace Va

16 (a) Informant Alma Scott (Wife)
(b) Address 412 N. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 10/9/46
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Cowley
(b) Address 1216 N. Carlton St.

19 OCT 10 1946 (Date accepted by local registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1946, at 2:15 P M

21. I certify that death occurred on the date above stated, at the hour stated, of the disease or condition mentioned, and that I attended deceased from Sept 1 19 46 to Oct 5 19 46, and that I last saw h[illegible] alive on Oct 1 19 46.

Immediate cause of death: Acute Regurgitation — Duration: unknown

Due to

Due to

Other Conditions Rheumatic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1274 Carlton St. Date signed 10/9/46

VS 190

G11115

502172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G11115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparks.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fairfax

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Molly.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-82.

8. AGE: Years	Months	Days	If less than one day
64	8	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name John W. Fairfax
13. Birthplace md

MOTHER
14. Maiden Name Annie Powell
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Mattamony Chapel
Location Sparks, Md.

18 (a) Funeral director Wm. J. Chatsman
(b) Address 1201 McCulloh St.

Oct 10 1946 (Signature and title) Huntington Hilliard M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1946 at 9.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1946, to Oct. 7 1946, and that I last saw him alive on Oct. 7 1946.

Immediate cause of death: CARCINOMA OF CECUM WITH METASTASIS TO REGIONAL

Duration: 1 day

Antecedent causes: HUMAN NODES AND LIVER

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hilliard S. Stephens M.D.
Address Johns Hopkins Hospital Date signed 10-9-46

VS 150

G44116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44116

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1159 Ward St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1159 Ward St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna D. Kraitman (or) Stone Rizzo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Albert C.
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 16 1897

8. AGE: Years	Months	Days	If less than one day
49	6	22	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Marion Coat Co

FATHER
12. Name Patrick Stone
13. Birthplace Balto

MOTHER
14. Maiden Name Eliza Edwards
15. Birthplace Balto.

16 (a) Informant Albert C. Kraitman
(b) Address 1159 Ward St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. end of North Ave.

18 (a) Funeral director M. W. E. Oppel's Sons
(b) Address Lombard & Ann Sts.

19 (a) (b) Huntington Williams, M.D.

OCT 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1946 at 6:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Oct 10 1946 and that I last saw alive on Oct 10 1946.

Immediate cause of death Acute Heart Failure — Duration —

Due to Hypertension — Duration —

Due to Chronic Heart Disease — Duration —

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin J. Glenn M. D.
Address 76 Wolfe St Date signed

X 10/10/46

G11117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1096

Registered No. G11117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Joffe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Phillip
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Yehuda
13. Birthplace Lith.

MOTHER
14. Maiden Name Trefka
15. Birthplace Lith

16 (a) Informant Hyman Joffe - Son
(b) Address 22 South Blvd - Rich. Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-11-46 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond Va.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St.

19 (a) Oct 10 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9th 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 46 to Oct 9 1946, and that I last saw h- alive on Oct 9 1946.

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other Conditions Dilated Heart	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus Rudecrel M.D.
Address 2225 Linden Ave Date signed 10/9/46

VS 150

G44118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2945 Greenmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2945 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine S. Lyons

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Frank A. Lyons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1873

8. AGE: Years	Months	Days	If less than one day
72	11	15	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Benjamine Shorten
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary ODonovan
15. Birthplace Ireland

16 (a) Informant Daniel J. Lyons
(b) Address 2945 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City

18 (a) Funeral director A. Vernon Lawrence
(b) Address 4611 Park Heights Ave.

19 OCT 10 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8th 1946 at 6.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1946 to 10-8 1946 and that I last saw h alive on 10/8 1946.

Immediate cause of death	Duration
Myocardial Insufficiency	24 hrs.
Due to Myocarditis	2 mos.
Due to Arteriosclerosis	1 year
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas J. White M. D.
Address 532 E. 22nd St. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G44419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Homewood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Homewood Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Alphonse C. Huber

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-09-2677

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie E. McCrear
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	25	ffffff min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Painter (House)
11. Industry or business

FATHER
12. Name Michael Huber
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Katie C. Huber
(b) Address 1313 Homewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave., Balto Co.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 OCT 10 1946 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9th., 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1946 to Oct 9 1946 and that I last saw h[illegible] alive on Oct 9 1946

Immediate cause of death: Pulmonary Edema
Due to: Cerebral Hemorrhage
Due to:
Other Conditions: Anaemia

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

Duration
-
3 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wesley D. Sikorsky M. D.
Address 939 N. Ellwood Date signed 10/9/46

G11150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G14450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 N.Bethel Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N.Bethel Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William J.O'Brien

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-07-3517

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth M.Silbert

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Oct. 6th., 1881

8. AGE: Years	Months	Days	If less than one day
65	0	2	##### min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gas & Electric Co, Balto

FATHER
12. Name John O'Brien
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Appolonia Kopf
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth M.O'Brien
(b) Address 1422 N.Bethel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto, Md.

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 10 1946 (b) Huntington Williams, M.D.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8th 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 8 1946; that I last saw h[e] alive on Oct 8 1946

Immediate cause of death	Duration	
Coronary Thrombosis	10 Min	
Due to Chr. Myocarditis	1944	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Rysanek M.D.
Address 801 4 Kenwood Ave Date signed 10/9/46

VS 150

G44151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No. G44151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison St.
(c) Hospital or institution: Maryland General Hospital 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos. 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Dobler Ave #18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Margaret Rose Peppler.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no
4. Sex: F.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: G. William Peppler
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 20, 1908
8. AGE: Years 37 | Months 11 | Days 19 | If less than one day: hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name John M. Busky
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name -- Geipe
15. Birthplace Balto., Md.

16 (a) Informant Mr. G. William Peppler
(b) Address 2109 Dobler Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 10 1946 (Date received by local registrar) (b) Thurlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1946, at 4 10/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1946 to Oct 9, 1946, and that I last saw h[illegible] alive on Oct 9 1946.

Immediate cause of death: Uraemia — Duration
Due to: Chronic glomerulo-nephritis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maynard Kyser M. D.
Address Maryland Gen. Hosp. Date signed 10/9/46

X

G44152
EN. 100799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1937

Registered No. G44152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo. & 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 665 George St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5th 1880

8. AGE: Years	Months	Days	If less than one day
66	7	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy Ave

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Bloomfield Ave

19 OCT 10 1946 Washington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8th 1946, at 8.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 23/ 1946, to Oct. 8. 1946, and that I last saw h im alive on Oct 8th 1946.

Immediate cause of death: Bronchopneumonia, Terminal — Duration 2 days
Due to
Due to
Other Conditions Hypertensive Heart Disease + Rheumatism
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed Oct 9 46

VS 150

107

G44153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178A

Registered No. G44153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Spring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Enoch Marks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Shannon, N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Miss Theresa Payne
(b) Address 118 Moore St. Fayetteville N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Pennsylvania ave

19 OCT 10 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 6 - 1946, at 3 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10 - 4 - 46 at 2 A. M.
(b) Where did injury occur? 213 Spring Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 2 burners on Kitchen Stove open

23. Signature Homer J. Chesser M.D. Medical Examiner.
Date signed 10 - 10 - 46

Form B. C. - signed - F. J. Stephens - J. H. H.

CHECK HERE IF INFORMATION SHOWN IS CORRECTED OR SUPPLIED. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44154 BALTIMORE CITY HEALTH DEPARTMENT G44154

CERTIFICATE OF DEATH 178A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N. Spring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALICE MARKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Enoch Marks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/28/1885

8. AGE: Years 61 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Fayetteville, N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joshua Payne
13. Birthplace N. C.

MOTHER
14. Maiden Name Lucy Ann Jenkins
15. Birthplace N. C.

16 (a) Informant Olivia Henry Petersburg Va.
(b) Address 182 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave

19 (a) (Date rec'd by registrar) OCT 10 1946 (b) Washington, Wilmington, N.C.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1946, at 4 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carbon Monoxide Gas Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury 10/4-46 at 2 A. M.
(b) Where did injury occur? 213 N. Spring Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 2 burners on Kitchen Stove of gas

23. Signature G. G. Merrill M.D. Medical Examiner.
Date signed 10/4/46

128

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44455 BG# F88526 BALTIMORE CITY HEALTH DEPARTMENT ✓14 CERTIFICATE OF DEATH Registered No. G44455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Nanny Lane + Harford Road
(c) Hospital or institution: Sydenham Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 Pearl St. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME Delores GRAHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 17 OCT 43

8. AGE: Years	Months	Days	If less than one day
2	11	22	hr. min.

9. Birthplace Baltimore, Baltimore, MD. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Nanny Graham
13. Birthplace S.C.

MOTHER
14. Maiden Name Victoria Singletary
15. Birthplace S.C.

16 (a) Informant VICTORIA GRAHAM
(b) Address 331 N. PEARL ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 12 46 (month) (day) (year)
(c) Cemetery or crematory MT. AUBURN CEM.
Location BALTIMORE Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 OCT 10 1946 Lexington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 OCT. 1946, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 OCT 1946, to 9 OCT 1946, and that I last saw h SHE alive on 9 OCT 1946

Immediate cause of death Tuberculous meningitis. — Duration

Due to

Due to

Other Conditions Tuberculous of Ear — Mastoiditis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Byron G. Dement M. D.
Address 814 Eutaw Place Date signed Oct 10 1946

X

G44456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 GEORGE. ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days) 43735

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 GEORGE. ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH. H BUTLER.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	COLORED	MARRIED

6 (b) Name of husband or wife LAURETTA —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-10-1873

8. AGE: yrs	Months	Days	If less than one day
64	9	30	hr. min.

9. Birthplace ST. MARYS COUNTY. MD. (Town, county, and state)
10. Usual Occupation LABORER.
11. Industry or business

FATHER
12. Name UNKNOWN.
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant LAURETTA BUTLER
(b) Address 713 GEORGE. ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-46 (month) (day) (year)
(c) Cemetery or crematory ST. Peters Cemetry
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) DEC 1 0 1946 (Date received by registrar) (b) Huntington Maryland (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1946 6:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 5 1946 to Oct 9 1946 and that I last saw h[illegible] alive on Oct 9 1946.

Immediate cause of death: Duration

Due to Arteriosclerosis Cardio Vascular Disease 1 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 713 E. Dean Date signed 10-10-46

G44157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44157 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Broad St., N.Y., N.Y. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leo WALKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 45 | Months | Days 2 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School

18 (a) Funeral director
(b) Address

OCT 10 1946 (Date rec'd by registrar)

OCT 10 1946
Commissioner of Health

(By) Hamilton G. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1946 at 1:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Accidental drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 10-2-46 at 10 A. 2/3 M.
(b) Where did injury occur? Found-foot of Fell St Thames Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 10/2/46

VS 181

Every item of information should be given if obtainable. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ X 1102

G44458
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Dover
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Baker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace (town, county, and state)
10. Usual Occupation Unknown
11. Industry or business Unknown

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 10 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 10 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3-1946, at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Fibrinopurulent pleurisy Empyema.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallonee M.D.
Medical Examiner.
Date signed 10-4-46

844459 G44459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dec
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 E. East 2nd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Peach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 10 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 10 1946 (Date received by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1946, at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature S. J. Gabrielson M.D.
Medical Examiner.
Date signed 10/4/46

G44160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44160 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline (Carrie) Walterhoefer-Childs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Charles A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1882

8. AGE: Years	Months	Days	If less than one day
64 yrs.	3	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Lillies
13. Birthplace unknown
MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Francis Joseph Childs - son
(b) Address 1714 Chilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

OCT 10 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1946, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1946 to Oct 8 1946, and that I last saw h[illegible] alive on Oct 7 1946.

Immediate cause of death — Duration

Coronary Thrombosis
Due to Chronic hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Seagrotta M. D.
Address 1224 W Lombard St Date signed Oct 9 '46

X

G44461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G44461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Brentwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine Westcott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John C. Westcott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-1903

8. AGE: Years	Months	Days	If less than one day
43	4	2	hr. min.

9. Birthplace Clarksburg, W. Va.
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace West Va

MOTHER
14. Maiden Name Kelly
15. Birthplace West Va

16 (a) Informant John West Cott
(b) Address 2402 Brent Wood AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 11 46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

(b) Filed by (Date received by Registrar) OCT 10 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1946, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1946, to 10/8 1946, and that I last saw h e r alive on 10/8 1946.

Immediate cause of death Cirrhosis OF Liver (Alcoholic)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald M. D.
Address Provident Hosp Date signed 10/9/46

G44162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G44162

Registered No.

Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Bronx
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 (Fenton) Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEONARD C. (ASMUDO) Asmundo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-28

8. AGE: Years	Months	Days	If less than one day
(19)18	6	16	hr. min.

9. Birthplace Bronx, New York
(Town, county, and state)

10. Usual Occupation U.S. Navy

11. Industry or business

FATHER
12. Name Leonardo Asmundo
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director J. Zuccolino & Sons
(b) Address 238 East 188 St. N.Y.C.

OCT 10 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1946, at 7.20 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Broken neck

Due to

Other Conditions Multiple fractures, lacerations, Brush Burns, & Abrasions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9-46 at approx. 7 P. M. Cattr. Co.
(b) Where did injury occur? Route #40- Phila. Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger-in car-struck by truck

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 10-10-46

(over)

G44163 B- 100048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson Jett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1869

8. AGE: Years 77 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Salmon Jett
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Ala.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 9 1946

18 (a) Funeral director
(b) Address Commissioner of Health

19 OCT 10 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1946, at 11:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1946 to Sept. 22 1946 and that I last saw h[im] alive on Sept. 22 1946

Immediate cause of death: Pulmonary Tuberculosis, Far-advanced — Duration: 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M.D.
Address Balt. Hosp. Date signed 10-3-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REPRODUCTION FOR BINDING

G44464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-104662

G44461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Not known

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Forest Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Shemmery or Robert Shannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
70 ?			hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace

MOTHER 14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 9 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 10 1946 Huntington Williams MD
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1946, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1946 to Sept. 23 1946, and that I last saw h. in alive on Sept. 23 1946.

Immediate cause of death	Duration
Bulbar Paralysis	3 mos.
Due to	
Due to	
Other Conditions Amyotrophic Lateral Sclerosis Aspiration Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hosp. Date signed 10-7-46 M. D.

G41165 - 104778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G41165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 W. Conway St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Saneveller or Peter Lanseveler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	29	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name George
13. Birthplace Russia

MOTHER
14. Maiden Name Eva ?
15. Birthplace Russia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 9 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 10 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1946, 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1946 to Oct. 2 1946, and that I last saw h im alive on Oct. 2, 1946.

Immediate cause of death Bronchopneumonia & Uremia

Due to Generalized arteriosclerosis with nephrosclerosis

Due to

Other Conditions Carcinoma of cystic and/or common bile duct.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Not above.

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. D. Gibbs
Address Baltimore City Hosp. Date signed 10/3/46

VS 180

1312

G44166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G44166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution: Mt Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 No Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 91 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Ada Gottlieb
(b) Address 1701 No Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 15-11-46 (month) (day) (year)

(c) Cemetery or crematory Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1424 E Balto St

19 OCT 11 1946 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10-1946 at 3:18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1943 to Oct. 9-1946 and that I last saw her alive on Oct-9-1946.

Immediate cause of death: senile arterio sclerosis —
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: Inde for Prob 10-15 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Herman Seidel M. D.
Address 2404 Eutaw Pl Date signed 10/10/46

VS 150

G14467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G14467

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 816 Chauncey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Brenner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Lith
13. Birthplace Russia

MOTHER 14. Maiden Name Rose Lith
15. Birthplace Russia

16 (a) Informant Herman Brenner
(b) Address 816 Chauncey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-46 (month) (day) (year)
(c) Cemetery, or crematory Hebrew Friendship Cemetery
Location Baltimore Md.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

DC 1-1 1946 (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1946 at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1946, to 10-10 1946 and that I last saw her alive on 10-10 1946

Immediate cause of death: Respiratory Failure — Duration

Due to: Metastatic Carcinoma

Due to: Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L M Krieger M. D.
Address Sinai Hosp. Date signed 10-12-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44168 — BALTIMORE CITY HEALTH DEPARTMENT — G44168

CERTIFICATE OF DEATH 1927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-11
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Underwood Road. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME A. William Field

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. A. William Field

6 (c) If alive, give age 60 yrs.

7. Birth date of deceased (mo., day, yr.): August 10 (1886)

8. AGE: Years 61 (60) Months 2 Days 0 If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation: President Elite Laundry

11. Industry or business: Laundry

FATHER
12. Name: I. S. Field
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Rosella Parsons
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Hospital Records
(b) Address: Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: John C. Mitchell & Sons
(b) Address: 1900 Eutaw Place

OCT 11 1946 (Date received) (b) Huntington Williams (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1946, at 1105 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1946 to Oct. 10 1946; and that I last saw h/ing alive on Oct. 10 1946.

Immediate cause of death: Pulmonary Edema — Duration: 5 days

Due to: Hypertensive Arteriosclerotic Heart Disease — 10 yrs.

Due to:

Other Conditions: Cardiac decompensation — 5 days
(Include pregnancy within 3 months of death)

PHYSICIAN — Underline the cause to which death should be charged statistically.

Date of operation:

Major findings of operation:

of autopsy: Cardiac enlargement, Chronic G

22. If death was due to external causes (violence), fill in also the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Norman R. Freeman Jr.
Address: Union Memorial Hosp. Date signed 10/9/46

(over)

G44169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G44169 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2077 E. Lafayette Ave
(c) Hospital or institution: G-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2077 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothea Brandt Walter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles F. Walter

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1895

8. AGE: Years 50 | Months 9 | Days 13 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Wm. Brandt

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Eva Gang

15. Birthplace Balto. Md.

16 (a) Informant Mary Coyne

(b) Address 2077 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/46 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville

18 (a) Funeral director C. D. Fanning & Son

(b) Address 1939 E. Lafayette Ave.

19 OCT 11 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9th 1946, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1946 to Oct 9 1946, and that I last saw him alive on Oct 8 1946.

Immediate cause of death: Cardiac Dilatation — Duration: 5 days

Due to: Diabetes Mellitus — 7 yrs

Due to: Acute Bronchopneumonia — 5 hrs

Due to: Glycosuria Intermittent Nephritis — 3 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Abrahms M.D.

Address 1015 Eutaw Pl Date signed 10/10/46

G44470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G44470 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINA ST.
(c) Hospital or institution: St Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 W 27th Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. CURRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife EFFIE E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	10	22		

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation PENSIONER.
11. Industry or business Balto Transit Co

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Effie E. Curry
(b) Address 535 W. 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Laurel

18 (a) Funeral director Kenneth V. Donovan
(b) Address 3615-17 Eastern Ave.

19 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-Oct 1946, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1946 to 10-11 1946 and that I last saw h[illegible] alive on 10-9 1946

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Myocardial degeneration	
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John B. Wells M. D.
Address St Jos. Hosp Date signed 10-10-46

VS 150 OCT 11 1946

K

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G11471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G11471 Registered No.

18-1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 W. Saratoga St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Johnson ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown 1895

8. AGE: Years	Months	Days	If less than one day
51	—	—	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Samuel Kelly
13. Birthplace Md.

MOTHER 14. Maiden Name Florence Murray
15. Birthplace Md.

16 (a) Informant Samuel Williams
(b) Address 625 Poca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Date received OCT 11 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1946, at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1946 to 10-8 1946, and that I last saw her alive on 10-8 1946.

Immediate cause of death	Duration
Cardiac Failure	
Congestive - Grade IV	
Due to Luetic Heart Disease	
& Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Arteriosclerotic and perforated peptic
of autopsy: ulcer, terminal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Workman M. D.
Address Univ. Hosp. Date signed 10-9-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44172
TN. 103982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 136

G44172
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave 19-2
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-month & 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
Street No. 103 N. Dunn Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9th 1902

8. AGE: Years 43 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Christy Ann ?
15. Birthplace ?

16 (a) Informant Helen Dorsey
(b) Address 1038 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
(Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1946, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22nd 1946, to Oct 10 1946, and that I last saw h.m alive on Oct 10th 1946

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Joseph H Bird M. D.
Address Balto City Hosps Date signed Oct 10 46

VS 150

X

P.D. 9-08942
G14473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G14473

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams 20-5 & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2647 Delaney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gearhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William J.
13. Birthplace Penna

MOTHER
14. Maiden Name Emma Tesche
15. Birthplace Germany

16 (a) Informant Mrs Margaret Tesche
(b) Address 2647 Delaney St

17 (a) Removal (b) Date thereof Oct 11 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenwood Mem. Park
Location New Kensington Penna.

18 (a) Funeral director Harry H. Wilka
(b) Address 4101 Edmondson Ave

OCT 11 1946 (b) Huntington Williams M.D.
(Date accepted by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1946, at 3:35 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1946 to 10-10 1946 and that I last saw h/he alive on 10-10 1946

Immediate cause of death	Duration
Immaturity	
Due to Immaturity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry H. Wilka M. D.
Address 4101 Edmondson Ave Date signed 10/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

G44174 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Ruskin Ave.
(c) Hospital or institution: 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Ruskin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary J. Underwood
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Joseph F.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 25, 1894
8. AGE: Years 52 Months 6 Days 14 If less than one day hr. min.
9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name John W. Meyer
13. Birthplace N.J.

MOTHER
14. Maiden Name Ella Cross
15. Birthplace Md.

16 (a) Informant Joseph F. Underwood
(b) Address 2205 Ruskin Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore
18 (a) Funeral director Martin Fahey & Son
(b) Address 1827 N. North Ave.
19 (a) Date received by registrar OCT 11 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1946, at 1 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Oct. 9, 1946 and that I last saw her alive on Oct 8 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 7 hrs
Due to: Hypertension — 10 yrs
Due to: Hypertension & C-V disease — 5 yrs
Other Conditions: Diabetes Mellitus, Bilateral glaucoma
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. H. Krenger M.D.
Address 428 Ningawa Date signed 10-13-46

93D

VS 150

G44175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G44175 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 4-7

(a) Baltimore City, Maryland

(b) Street address Laymen & Cleveland

(c) Hospital or institution West Baltimore Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 230 N. Greene St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hazel Lusk.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	

6 (b) Name of husband SAMUEL P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 1 1903

8. AGE: Years	Months	Days	If less than one day
43	05	9	hr. min.

9. Birthplace Jeffersville, Ind. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER

12. Name MINOS S. McNEELY

13. Birthplace IND.

MOTHER

14. Maiden Name BERTHA STRONG

15. Birthplace IND.

16 (a) Informant MRS. BERTHA McNEELY

(b) Address 1371 W. 27TH ST. Balto. Md.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof OCT 12, 1946 (month) (day) (year)

(c) Cemetery or crematory OAK GROVE

Location SARVER, PENNA.

18 (a) Funeral director WILLIAM COOK, INC.

(b) Address 1217 ST. PAUL ST.

19 (a) (Date received by Registrar) OCT 11 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1946, at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Oct. 9 1946 and that I last saw he alive on October 9 1946

Immediate cause of death	Duration
Cardiac Decompensation	
Probable	
Due to Rheumatic C.V. Dis. Mitral Stenosis + Insuff.	
Due to Aortic Insuff. + Hydrothorax, Rt.	
Other Conditions Subacute Bact. Endocarditis, Path.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leon Jan d'Stall M.D.

Address Balto. Gen. Hosp. Date signed 10/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT G14176 ✓

TN. 101588 G14176 CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave 13-3
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- mo. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2630 Flora St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Downey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4th 1905

8. AGE: Years 40 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm Albert Downey
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Preston
15. Birthplace Penna

16 (a) Informant Clara Downey
(b) Address 2630 Flora St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Belson
(b) Address 1303 Pennsylvania Ave

19 OCT 11 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Oct 8th 1946 19 , at 7.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16th 1946 to Oct 8 th 1946.
and that I last saw h im alive on Oct 8th 1946.

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 2 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Bird M. D.
Address Balto City Hosps Date signed Oct 10 46

X

VS 190

G44177 G44177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town LAUREL
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK KRAUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 [illegible]

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13-1946 (month) (day) (year)
(c) Cemetery or crematory Berry Hill Cemetery
Location Laurel P.G. County, Md.

18 (a) Funeral director R. Selby
(b) Address Laurel, Maryland

19 (a) OCT 11 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1946, 11.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema.
Diffuse capillary hemorrhages.
Due to

Other Conditions Arteriosclerosis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/10/46

VS 151

111 B

G44178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G44178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. BLANKS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 700 West 40th St
(c) Hospital or institution:
Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs 2 mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Many years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Keswick Rd. & 40th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Adelaide R. Harris.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Louis M. Harris,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8- 1867.

8. AGE: Years	Months	Days	If less than one day
79	5	2	hr. min.

9. Birthplace Philadelphia, Penna
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Home for Incurables
(b) Address 700 West 40th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1946, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5th 1935 to Oct. 10 1946 and that I last saw h[illegible] alive on Oct 9th 1946

Immediate cause of death: Gangrene right foot — Duration 2 months
Due to: Arteriosclerosis changes of widespread nature — Unknown
Due to: Arteriosclerosis & Hypertension Cardio Vascular Disease — 10 years
Other Conditions: Multiple arthritis changes (Arthritis Deformans) — 10 years
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolff M. D.
Address 11 E. Chase St. Baltimore, Maryland
Date signed 10/11/46

G11473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G11473

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 Poplar Grove St.
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD G. JOHNSON, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Alice M. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1883

8. AGE: Years	Months	Days	If less than one day
63	1	14 17	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Wm. Boucher & Sons

FATHER
12. Name Jacob Cummings
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Jane Brannen
15. Birthplace New Jersey

16 (a) Informant Mrs. E. G. Johnson
(b) Address 1726 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1946 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Oct. 9, 1946 and that I last saw him alive on Oct. 9, 1946.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Hypertension - about	4 yrs.
Due to	
Other Conditions Advanced Arterio-sclerosis ? (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hall Dubbs M. D.
Address 2220 Garrison Blvd. Date signed 10/11/46

G44180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G44180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-1
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS E. JEFFERSON

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary C.
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.): May 16-1885
8. AGE: Years 61 | Months 4 | Days 23 | If less than one day: hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Boat Builder
11. Industry or business: U.S. Coast Guard

FATHER
12. Name: Joseph Jefferson
13. Birthplace: Md

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mary E. Jefferson
(b) Address: 3470 Wilkins ave

17 (a) Burial: Burial (Burial, cremation, or removal) (b) Date thereof: Oct 14-1946 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: City

18 (a) Funeral director: Pott & Burke
(b) Address: Pott & Sticks Co.

19 (a) Filed: OCT 11 1946 (b) Registrar: Huntington Williams M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1946, at 5.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Intra cerebral Hemorrhage
Mitral Stenosis

Due to

Other Conditions: Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 10-10-46

G11181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G11181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 10-1
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Georgiana Dorsey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1867

8. AGE: Years	Months	Days	If less than one day
79	3	3	hr. min.

9. Birthplace St. Mary's County Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Mary ?
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rida Wudefeld
(b) Address 900 East Biddle St.

19 (a) OCT 11 1946 Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 11- 1946, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1- 1946, to Oct 11- 1946, and that I last saw her alive on Oct 10- 1946.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Av Date signed 10/11/46

G44182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G44182 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-6
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 655 Parnell ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Cadwell Grammer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. married.
6 (b) Name of husband or wife Wm. F. Grammer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 17, 1884
8. AGE: Years 62 yr. Months 7 Days 27 If less than one day hr. min.
9. Birthplace Balto. Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Dare
13. Birthplace Maryland.

MOTHER
14. Maiden Name Annie Wells
15. Birthplace Maryland.

16 (a) Informant Husband.
(b) Address same as above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Govans Md.

18 (a) Funeral director Sulzby & Shubert
(b) Address 403 S. Wolfe Street

19 (a) Date received 10 11 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1946 to 10/9 1946, and that I last saw him alive on 10/9/46 1946.

Immediate cause of death Brain Tumor — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/6/46

Major findings of operation: Infiltrating tumor, frontal, dextra & Colloid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Watson M. D.
Address Church Home & Hosp. Date signed 10/9/46

over

VS 180

C14183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C14183

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2921 Rosalie Avenue
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Rosalie Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine M. BARBERA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Jos.

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 187[illegible]

8. AGE: Years 74 | Months 3 | Days 17 | If less than one day hrs. min.

9. Birthplace Marsalla Italy
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Vincent Sandicina

13. Birthplace Italy

MOTHER 14. Maiden Name —

15. Birthplace Italy

16 (a) Informant Mr. Anthony Barbera

(b) Address 2921 Rosalie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director J. V. Pipkorn

(b) Address 2818 E. Baltimore St

19 (Date rec'd by registrar) OCT 11 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/1946, at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22 If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John C. Weiss, M.D. Medical Examiner.

Date signed 10/11/46

VS 151

G34181 FRANK O. Lechte X ✓ G34181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Smith Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank O. Lechte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1900 1895

8. AGE: Years	Months	Days	If less than one day
46	8	8	hr. min.

9. Birthplace Baltimore Md (Town, county, or state)

10. Usual Occupation Steam-fitter

11. Industry or business

FATHER
12. Name Frank Lechte
13. Birthplace — Md.

MOTHER
14. Maiden Name Ada Ritter
15. Birthplace — Md.

16 (a) Informant Frank Lechte
(b) Address Smith Ave - Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Leonard J. Lucke
(b) Address 5505 Harford Road

OCT 11 1946 Huntington Williams (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1946 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1946 to 10-10 1946 and that I last saw him alive on 10-10 1946.

Immediate cause of death: Cardio-resp. failure — Duration

Due to Congestive Heart failure

Due to Hypocardial degeneration

Other Conditions Coronary sclerosis Cerebral embolism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. May M. D.
Address Calvert & Saratoga Date signed 10-10-46

546. X

VS 150

G14185

Dr. Ed Kallins
1847 W. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G14185

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1841 West North Avenue
(c) Hospital or institution: 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 West North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bridget O'Neill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife ------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1863

8. AGE: Years	Months	Days	If less than one day
83	9	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Burns
15. Birthplace Ireland

16 (a) Informant Miss Helen M. Carey
(b) Address 1841 West North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 OCT 11 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946, to Oct 9 1946, and that I last saw h[illegible] alive on Oct 9 1946

Important causes of death | Duration
Hypertensive Cardio Vasc. Dis | 5 yrs
Due to
Due to
Other Conditions Senility

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Kallins
Address 1847 W. North Date signed Oct 10/46

VS 150

X

G44186 — 10C# 957851 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 157E — R. G44186

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore 21 Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 166 Renwick Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Matthews

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 AM 9/11/46

8. AGE: Years | Months | Days: 22 | If less than one day: hr. min.

9. Birthplace Baltimore MD (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER — 12. Name James Heap Matthews
13. Birthplace

MOTHER — 14. Maiden Name Anna Catherine McKenney
15. Birthplace

16 (a) Informant Anna Matthews
(b) Address 166 Renwick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Jerusalem Hill Rd.

18 (a) Funeral director John F. Connelly
(b) Address Essex, Md.

OCT 11 1946 Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1946 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1946 to 10/10 1946, and that I last saw him alive on 10/10 1946.

Immediate cause of death: Congenital Heart disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Hosp Date signed 10/10/46

G11187 BALTIMORE CITY HEALTH DEPARTMENT X V G11187

CERTIFICATE OF DEATH 45c

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 441 1st St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Lynch, Bernard Joseph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Calahan
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 18, 1886

8. AGE: Years	Months	Days	If less than one day
60	4	22	hr. min.

9. Birthplace Brooklyn, NY (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Martin Lynch
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Larkin
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Remard (Burial, cremation, or removal) (b) Date thereof 10/4/46 (month) (day) (year)
(c) Cemetery or crematory St Joseph Cem
Location Brooklyn N.Y.

18 (a) Funeral director Wm Cook 2nd
(b) Address 1217 St Paul St

OCT 11 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1946, 3:10P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1946, to Oct. 10 1946, and that I last saw him alive on Oct. 10 1946.

Immediate cause of death Squamous cell carcinoma of mucous membrane of mouth involving left anterior tonsillar pillar and with extension to pharynx. — Duration ONE YEAR

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 10/11/46

G44188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G44188

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine King

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George J. King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1860

8. AGE: Years	Months	Days	If less than one day
85	11	25	hr. min.

9. Birthplace Towson Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wenderoth
13. Birthplace Germany

MOTHER
14. Maiden Name Kaisah Herman
15. Birthplace Towson, Md.

16 (a) Informant Beatrice Carter
(b) Address 2119 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

OCT 12 1946
(Date rec'd by registrar)
Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Oct 9 1946 and that I last saw h[illegible] alive on Oct 9 1946

Immediate cause of death	Duration
(a) Coronary thrombosis	24 hrs
Due to (b) Cardiac insufficiency	2 days
Due to (c) Senile degeneration	3 yrs

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roscoe G. Carter M. D.
Address 2438 Maryland Ave Date signed 10-10-46

VS 150

18 + Cert

G44189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

G44189 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Use correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St.
(c) Hospital or institution Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 months 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Charles Floyd

3 (b) If veteran, name war W
3 (c) Social Security Account No. [illegible]

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced widower

6 (b) Name of husband or wife Marie M. Gustaves Floyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1872

8. AGE: Years 74 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Fire Business
11. Industry or business

FATHER
12. Name James L. Floyd
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna L. Hardiman
15. Birthplace Baltimore, Md

16 (a) Informant Home for Incurables Records
(b) Address 700 W. 40th St. Balto, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St Paul St.

19 (a) Huntington Williams, M.D. (b) Registrar
(Date received by registrar) OCT 12 1946

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1946, at 10.19 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31/43 1943 to 10/10 1946 and that I last saw [illegible] alive on 10/10 1946.

Immediate cause of death Myelomalacia — Duration 5 years
Due to Arteriosclerosis (Duration) 10 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hargrave M.D.
Address 214 Medical Arts Bldg The signed 10/9/46

X

G44190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered No. G44190

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Patapsco
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel M. Amey

3 (b) If veteran, name war W

3 (c) Social Security Account No. DIDE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband Raymond Amey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31st 1909

8. AGE: Years 36 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name David Brice
13. Birthplace Unknown

MOTHER
14. Maiden Name Emma Weichart
15. Birthplace Balto. Md.

16 (a) Informant Virginia Amey
(b) Address 505 Patapsco Ave

17 (a) Burial (b) Date thereof 10/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ~~Filed~~ (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/46 19 , at 6:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions Lacerated Wrists

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/10/46 at 2:00 P.M.
(b) Where did injury occur? Home (511 Patapsco)
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self Inflicted

23. Signature John C. Lawn M.D.
Medical Examiner.
Date signed 10/11/46

644191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G44191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Drive & 31st St.

(c) Hospital or institution:
US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 101 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 832 Union Ave.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wentworth, Cecil Eric

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	217-03-1125

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillian Noland Wentworth
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1887

8. AGE: Years	Months	Days	If less than one day
59	8	0	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name John Ira Wentworth
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary Frances Wilson
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12-1946 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3691 Falls Road

19 OCT 12 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1946, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to Oct. 10 1946.
and that I last saw him alive on Oct. 10 1946.

Immediate cause of death Primary lesion within left kidney with metastasis to lung.

Duration 6 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John L. Wilson

John L. Wilson, Sr. Surgeon M. D.

Address Clinical Director Date signed 10/10/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 N. 36th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, state Ward and give town)
(d) Street No. 846 N. 36th Street (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Cora L. Durham

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George N. Durham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17-1871

8. AGE: Years	Months	Days	If less than one day
75	4	23	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name	Lewis Thompson
FATHER 13. Birthplace	Virginia
MOTHER 14. Maiden Name	Elizabeth —
MOTHER 15. Birthplace	Virginia

16 (a) Informant Mrs. Lillian E. Armiger
(b) Address 846 N. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14-1946 (month) (day) (year)
(c) Cemetery or crematory Woodbirch Memorial Park
Location Howard Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Date received by local registrar OCT 12 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 - 1946 at 12-10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 10 1946 and that I last saw h[illegible] alive on Oct 10 1946.

Immediate cause of death	Duration
Coronary occlusion.	sudden.
Due to Chronic cardio-vascular disease.	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cora L. Durham
Address 846 N. 36th St. Date signed 10/10/46

VS 150

G4493 ✓ G4493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Hollins St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) ✓
If yes, name country

3 (a) FULL NAME CHARLES GAUNAS

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	215-07-2471

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Widowed

6 (b) Name of husband or wife Albina
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Jr. Gaunas
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant John Galines
(b) Address 701 W Lombard St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd
18 (a) Funeral director Joseph Rasinskas Inc
(b) Address 1 Washington Blvd
19 (a) Huntington Williams M.D.
(Date rec'd by registrar) OCT 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1946, at 7 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1946 to 10/10 1946, and that I last saw HIM alive on 10/9 1946.

Immediate cause of death TERMINAL BRONCHO PNEUMONIA AND RESPIRATORY DEPRESSION — Duration 1 DAY
Due to CEREBRAL VASCULAR ACCIDENT
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE
Other Conditions AURICULAR FIBRILLATION
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles W. Stewart Jr M.D.
Address MD. GEN. HOSPITAL Date signed 10/10/46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G11191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G11191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 E. University Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: PHILIP J. PETERS, SR.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-03-1276

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Catherine Peters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 7, 1893

8. AGE: Years 53 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace: Alexander, Va. (Town, county, and state)

10. Usual Occupation: V. P.

11. Industry or business: Comfort Spring Corp.

FATHER
12. Name: Joseph J. Peters
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Minnie A. Norris
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Philip J. Peters, Jr.
(b) Address: 324 E. University Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (Date rec'd by registrar) OCT 12 1946 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 | 10 | 46 19 9:40 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 10 | 11 | 46

G11495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G11495 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Northview Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD A. CHENOWITH

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 212-10-9878A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Ida L. Chenowith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1873

8. AGE: Years	Months	Days	If less than one day
73	7	16	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired 12 yrs.
11. Industry or business

FATHER
12. Name Wm. Chenowith
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden Name Mary Grimes
15. Birthplace Cumberland, Md.

16 (a) Informant Dr. Robert F. Chenowith
(b) Address Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

19 OCT 12 1946 (Date rec'd by Registrar) Clayton Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1946 at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Sept. 1946 to 10 Oct. 1946 and that I last saw him alive on 10 Oct. 1946.

Immediate cause of death	Duration
Myocardial failure.	2 days
Due to Sy Myocarditis and Generalized Arteriosclerosis	
Due to	
Other Conditions Cerebral Thrombosis	1 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed 11 Oct 1946

VS 150

G11196

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G11196
CERTIFICATE OF DEATH 133B Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6410 Pinehurst Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA S. WINKELMAN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Wm. H. Winkelman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1872

8. AGE: Years 73 | Months 10 | Days 9 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Louis Aull
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Shamleffer
15. Birthplace: Woodensburg, Md.

16 (a) Informant: Mrs. Donald Wilson
(b) Address: 6410 Pinehurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (Date received by registrar) OCT 12 1946 (Signature of registrar) Huntington Wilkinson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1946, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1944 to Oct 10 1946 and that I last saw h[er] alive on Oct 9 1946.

Immediate cause of death: Myocardial Failure & Renal Insufficiency — Duration: 5 mos.
Due to: Chronic Arteriosclerosis — Duration: many years.
Due to: Hypertension
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Carroll Stoklard M. D.
Address: 2925 N. Charles St. Date signed: 11 Oct 46.

G14197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G14197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 N Glover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N Glover
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J Winfelder

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband Barbara Winfelder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6 1866

8. AGE: Years	Months	Days	If less than one day
79	11	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Painter

FATHER
12. Name John Winfelder
13. Birthplace Germany

MOTHER
14. Maiden Name Helen Kratzer
15. Birthplace Germany

16 (a) Informant John Winfelder
(b) Address 224 N Glover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location City

18 (a) Funeral director Ulbrich Funeral Home
(b) Address 2108 Allegheny Ave

19 (Local Registrar) OCT 12 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1946, at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Oct. 9, 1946 and that I last saw him alive on Oct 9, 1946

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Moore M.D. M. D.
Address 448 N. Luzerne Ave Date signed 10-10-46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G11498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G11498

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 218 E. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Schaumloeffer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife Geo. M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1876

8. AGE: Years	Months	Days	If less than one day
70	-	28	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Joseph Schnitzler
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Carolyn Powers
(b) Address 1300 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave

18 (a) Funeral director John F Kenny Inc
(b) Address 711 Light St. Huntington Williams, Mgr.

19 (a) (Date received by Registrar) (b) Registrar

OCT 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1946 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Oct 11 1946 and that I last saw him alive on 10-11-1946

Immediate cause of death Coronary thrombosis pneumonia — Duration 1 yr.

Due to Advanced Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. V. Rangle M.D.
Address 642 Wash Blvd Date signed 10-12-46

R.V. Rangle

G11199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1062

Registered No. G11199

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 Scott ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Scott ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adolphus J. Carey

3 (b) If veteran, name war –
3 (c) Social Security Account No. 262-09-5181

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Ellen L. Carey
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) July 4, 1885

8. AGE: Years	Months	Days	If less than one day
61	2	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bakers Helper
11. Industry or business Bakery

FATHER
12. Name William Carey
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Long
15. Birthplace England

16 (a) Informant Ellen L. Carey
(b) Address 307 Scott ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore, Md

18 (a) Funeral director Durward L. Courtney
(b) Address 21 W. 20th ST

OCT 12 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1946, at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1946 to Oct 10 1946 and that I last saw him alive on Oct 10 1946

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to Chronic Bronchitis & Emphysema	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Huntington Williams M. D.
Address 888 W. Lombard St Date signed 10-11-46

VS 180

1500 BALTIMORE CITY HEALTH DEPARTMENT X ✓ C41500
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Emerald Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry B. Wills
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Clara B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1884

8. AGE: Years	Months	Days	If less than one day
62	3	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Filling Station Operator
11. Industry or business

FATHER: 12. Name John Wills
13. Birthplace Md

MOTHER: 14. Maiden Name Elizabeth ?
15. Birthplace ?

16 (a) Informant Clara B. Wills
(b) Address 2906 Emerald Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Rusk
(b) Address 6305 Harford Rd.

OCT 12 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1946, at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1946, to Oct 11 1946, and that I last saw h[illegible] alive on Oct 11 1946

Immediate cause of death	Duration
Spontaneous Rupt of Heart	5 min
Due to Myocardial Infarction	3 wks
Due to Coronary Sclerosis	5 yrs
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Rupt of Left Ventricle

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. K. Sauthoff
Address Franklin Sq. Hosp. Date signed 10/12/46

X

G41501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G41501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 n. Gilmore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 n. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meade C. Palmer sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C	married

6 (b) Name of husband or wife Julia Palmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1878

8. AGE: Years	Months	Days	If less than one day
68	8	5	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Meade C. Palmer Jr.
(b) Address 1209 n. Gilmore St

17 (a) Burial (b) Date thereof 10-13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Warsaw Va
Location

18 (a) Funeral director George E. Watson
(b) Address 1303 Pennsylvania Ave

OCT 12 1946 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1946, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Oct. 10 1946 and that I last saw h[illegible] alive on Oct 9 1946.

Immediate cause of death

	Duration
Cerebral Hemorrhage	6 weeks
Due to Arteriosclerosis	-
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Bradshaw Higgins M.D.
Address 2243 Madison Ave Date signed 10/11/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~C44502~~

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 131B

Registered No. C44502

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Young Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2Wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town White Stone (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1 Box 158 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. COTTMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/1876

8. AGE: Years	Months	Days	If less than one day
69	10	12.	hr. min.

9. Birthplace Accomac, Co, Va. (Town, county, and state)
10. Usual Occupation Oyster Packer
11. Industry or business

FATHER
12. Name Frank Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Lola Evans
15. Birthplace Va.

16 (a) Informant Mamie Conquest (Daughter)
(b) Address R.F.D. 1, Box 158, Whitestone Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Vernon
Location White Stone, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

OCT 12 1946 (Date Rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/46 19 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Oct. 7 1946 and that I last saw him alive on Oct. 7 1946.

Immediate cause of death

	Duration
Chronic myocarditis	15
Uremia	2d
Due to Chr. Nephritis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Perry M. D.
Address 1420 E. Chase Date signed 10-12-46

VS 150

G41503 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G41503

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... D.H.A.
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ...
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Slade Ave (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Bertha Petri

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife ...
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 23 - 1881

8. AGE: Years	Months	Days	If less than one day
65	5	16	... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name George Petri
13. Birthplace Germany.

MOTHER
14. Maiden Name Augusta Fusher
15. Birthplace Balto. Md.

16 (a) Informant Mrs Wm. Woehlke
(b) Address 1727 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 - 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 [illegible]

OCT 12 1946 (Date rec'd by registrar) (b) ... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1946, at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to ...

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur? ...
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work? ...
(d) Means of injury ...

23. Signature P. J. Lubinski M.D. Medical Examiner.
Date signed 10/13/46

C14501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. C14501

CHK-104917

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or other (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 0 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 S. Pace Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tressa Stickel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26 1898

8. AGE: Years	Months	Days	If less than one day
48	0	15	hr. min.

9. Birthplace Maryland (Town, county, or state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rudolph Hauck
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Bangen
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue 10/14/46

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Fred. Ave

18 (a) Funeral director Geo. Leymbach
(b) Address 725 N. Lynchburst Ave.

19 OCT 12 1946 Huntington Williamsport Md
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1946, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1946 to Oct. 11 1946, and that I last saw her alive on Oct. 11 1946.

Immediate cause of death: Respiratory failure — Duration

Due to Atelectasis

Due to

Other Conditions Malignant lymphoma
Exfoliative
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Malignant lymphoma

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Doyle Waldron M. D.
Address BCH Date signed 10/14/46

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 150

G34505

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G34505
Registered No.

CERTIFICATE OF DEATH 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown. (If outside city or town limits, write RURAL and give town)
(d) Street No. Randallstown Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew J. Smith.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1865

8. AGE: Years 81 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Elkins W. Va. (Town, county and state)

10. Usual Occupation Retired Farmer.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Phoebe Smith
15. Birthplace Harmon W. Va.

16 (a) Informant Mr Dickson Smith
(b) Address 10 E. Pery St Balto 2 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 46 (month) (day) (year)
(c) Cemetery or crematory Int. Olive Mem. Gdns
Location Randallstown Md

18 (a) Funeral director Mamie Cook Lyfer
(b) Address 1600 W. North Ave.

19 OCT 12 1946 (c) Huntington Nelligan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11, 1946 at 6 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1946 to Oct 11 1946 and that I last saw him alive on Oct 10 1946.

	Duration
Immediate cause of death: Coma	
Due to: Cerebral hemorrhage	
Due to: Fracture of 5th thoracic vertebra with subadventitial	
Other Conditions: Hemorrhage of aorta. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Oct 10th at a.M
(c) Where did injury occur? Randallstown Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury fell down stairs

23. Signature Wilmot Clyde M. D.
Address Md. Gen. Hospt. Date signed 10/16/46

VS 150

Ile O. J. Zulewsky, by Howard J. McInnis, M. D.

G41506 3037 O'Donnell St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 B

Registered No. G41506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 S. Potomac Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy (Dora) Hooper

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Chas.F. Hooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/74

8. AGE: Years 72 | Months 1 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Morris
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland

16 (a) Informant Chas. F. Hooper (hus)
(b) Address 913 S. Potomac Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East End of North Ave.

18 (a) Funeral director Lilly & Gaither Inc.
(b) Address 403 S. Wolfe Street
OCT 12 1946 Huntington Williams M.D. (Signature of City Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1946, at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1946 to Oct. 9, 1946, and that I last saw h er alive on Oct. 9, 1946

	Duration
Immediate cause of death: Myocardial insufficiency	3 days
Due to: Chronic bronchitis	3 months
Due to: Arterio-sclerosis	10 years
Other Conditions: Pulmonary edema	12 hrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. A. Kronshaw M.D.
Address 3037 O'Donnell St Date signed 10-12-46

VS 150 x9

G11807 Dr. Hunt 3215 Baker Av

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G11507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Write out the full name and address. Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 S. Clinton Street
(c) Hospital or institution:

26 life
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 S. Clinton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Mary M. Huth

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/ 28/76

8. AGE: Years	Months	Days	If less than one day
70	8	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Dress maker
11. Industry or business slef

FATHER
12. Name Jacob Huth
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Denner
15. Birthplace Germany

16 (a) Informant Catherine Huth (sis)
(b) Address 614 S. Clinton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ 13/ 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Seiler Inc.
(b) Address 403 S. Wolfe Street

19 OCT 12 1946 (Date rec'd by registrar) Thomas Williamson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1946 to 10/10 1946
and that I last saw h. LY alive on 10/10 1946

Immediate cause of death Carcinomatosis — Duration

Due to Metastasis from Carcinoma of the breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which of these) While at work?
(e) Means of injury

23. Signature Charles H. Slone, M.D.
Address 321 Cathedral Date signed 10/12/46

G14508 BALTIMORE CITY HEALTH DEPARTMENT G14508
Registered No.

CERTIFICATE OF DEATH 46H

502309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York. (If outside city or town limits, write RURAL and give town)
(d) Street No. 441 N. Beaver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Ea. Banton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Margaret.
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 5-5-87.

8. AGE: Years 59. | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Bus Dispatcher
11. Industry or business

FATHER
12. Name Frank Banton
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane McGargan
15. Birthplace Pa.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 10-15-1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location York. Pa.

18 (a) Funeral director Wilbur Cook Dept
(b) Address 1217 St Paul St

OCT 23 1946 (Date Rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1946 at 6.05 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-5 1946 to Oct-12 1946, and that I last saw him alive on Oct-12 1946.

Immediate cause of death: Retroperitoneal Lymphoblastoma with extensive metastases — Duration

Due to

Due to

Other Conditions Adhesive pericarditis Calcific aortic stenosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A.M. Knight M. D.
Address Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

✓ G44509 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2241 Kirk Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2241 Kirk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

9 18

3 (a) FULL NAME Susie W. Albers

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Christopher Albers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1882

8. AGE: Years	Months	Days	If less than one day
64	6	18	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Henninger
15. Birthplace Pa.

16 (a) Informant Christopher Albers
(b) Address 2241 Kirk Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 14/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location York Pa.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (b) Registrar

OCT 15 1946

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12/46 19 , at 3:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27th 1946 to Oct. 12th 1946, and that I last saw her alive on Oct. 11th 1946.

Immediate cause of death	Duration
Carcinoma of Liver	about 4mos
Due to Adenocarcinoma of the hepatic flexure, transverse colon	unknown
Due to	
Other Conditions Secondary Anemia	4 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo. W. Morgan Jr. M.D.
Address 401 E. 25th. St. Date signed 10/12/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44510 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution: Mt Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Lucille Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Fishman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant A. H. Mandelberg

(b) Address 20 E Eutaw Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Poly Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 614 E Baltimore St

OCT 15 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1946 at 11:7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Oct 12 1946, and that I last saw h[illegible] alive on Oct 12 1946

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Hypertensive Cardiovascular Renal Disease	1 yr
Due to Arteriosclerosis	1 yr.
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter S. Lowman

Address 4843 Park Heights Ave Date signed 10/12/46

VS 150

G14511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G14511 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL or give town)
(d) Street No. 531 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Geker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife David
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68	2 mo		hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wredel Ackerlich
13. Birthplace Lith

MOTHER
14. Maiden Name Sarah Lith
15. Birthplace

16 (a) Informant Abraham Cohen
(b) Address 531 Sharp St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10-13-46 (month) (day) (year)
(c) Cemetery or crematory Mt Sinai
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1498 Baltic St

19 (a) OCT 13 1946 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/1946, at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 46 to 10/12 1946, and that I last saw h alive on 10/12 1946.

Immediate cause of death

	Duration
Carcinoma of Breast	3 yrs
Due to	
Due to	
Other Conditions Cachexia Metastases to Lung	3 mos

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D.
Address 122 S Charles St Signed M. D.

VS 150

X 10 Lith

G44512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

✓ G44512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves.
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Narragansett (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Arthur Wolfsheimer

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9 1889

8. AGE: Years	Months	Days	If less than one day
62	5	2	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nathan Wolfsheimer
13. Birthplace Germany

MOTHER
14. Maiden Name Babett Schooler
15. Birthplace Balto. Md.

16 (a) Informant Evelyn Wolfsheimer
(b) Address 2329 Eutaw Place

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct 15 46
(c) Cemetery or crematory Baltimore Hebrew Cemetery
Location Belair Rd

18 (a) Funeral director D. Ahrens & Co.
(b) Address 2416 Reisterstown Rd

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/46 19 at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11/46 19 to 10/11 19 46 and that I last saw him alive on 10/11 19 46

Immediate cause of death Acute Myocarditis

Due to Cerebro Vascular Accident

Due to Arteriosclerosis & Hypertension

Other Conditions Coronary Thrombosis, Auricular Fibrillation, Hemiplegia (R) Chronic Lobar Pneumonia (Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation
of autopsy: Yes Dr. Dana

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature Irving Root M. D.
Address Sinai Hospital Date signed 10/14/46

Covington Williams, M.D.

935

G11513 — BALTIMORE CITY HEALTH DEPARTMENT XV G11513 — Registered No.

CERTIFICATE OF DEATH 45F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Emmitsburg
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anna Louise McGrath

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8th 1869

8. AGE: Years 77 | Months 6 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Emmitsburg, Md. (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER — 12. Name James J McGrath
13. Birthplace Dublin, Ireland

MOTHER — 14. Maiden Name Annie Neusier
15. Birthplace Emmitsburg, Md.

16 (a) Informant Mr. James L. Zrugable
(b) Address 1305 Gorsuch Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery St Joseph
Location Emmitsburg, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna Aves.

19 (a) OCT 13 1946 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/46 19— at 1 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 19 46 to 10/12 19 46.
and that I last saw h CY alive on 10-12 19 46.

Immediate cause of death — Duration

Due to Carcinoma throat, for advanced -

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Langley M. D.
Address Saint Agnes Hospital Baltimore, Md. Date signed 10-13-46

X

G14514 — 502314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G14514 — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 Woodyear St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellis West.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	married

6 (b) Name of husband or wife Nancy

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 4-5-87

8. AGE: Years	Months	Days	If less than one day
59.	6	5	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Christopher West

13. Birthplace Va.

MOTHER — 14. Maiden Name Katz Williams

15. Birthplace Va.

16 (a) Informant Record

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn. Location Md

18 (a) Funeral director George G. Nelson

(b) Address 1203 Pennsylvania Ave

19 (a) Filed by relative (b) Registrar Leighton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 - 1946. at 5.14 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct- 8 1946 to Oct- 10 1946. and that I last saw him alive on Oct 10 1946

Immediate cause of death GENERALIZED PURULENT PERITONITIS — Duration ± 1 wk

Due to RUPTURE OF BOWEL

Due to CAUSE UNKNOWN

Other Conditions ARTERIOSCLEROTIC HEART DISEASE.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Stephens M. D.

Address Johns Hopkins Hospital Date signed 10-12-46

VS 150

1222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44515 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6508 Brook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6508 Brook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN V. KUCERA

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife: Mary (nee Lechecka)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/24/1866

8. AGE: Years	Months	Days	If less than one day
80 yrs.	3	15	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frank Kucera
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Mary Rose - daughter
(b) Address 6508 Brook Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or Crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (b) Registrar

OCT 15 1946 Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1946 at 10:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1941 to 10/9 1946 and that I last saw h. alive on 10/9/1946.

Immediate cause of death: Coronary Artery Thrombosis — Duration 4 days

Due to (Arteriosclerotic Heart Disease — 5 years

Due to

Other Conditions Senility —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Kucera M.D.

Address 6331 Belair Rd. Date signed 10/10/46

X

G14516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G14516 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 E. Ellsworth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert J. Hoffheiser

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/25/43

8. AGE: Years	Months	Days	If less than one day
3	2	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name Norman Hoffheiser
	13. Birthplace Balto. Co. Md.
MOTHER	14. Maiden Name Margaret Rothlingshofer
	15. Birthplace Balto Md.

16 (a) Informant Norman Hoffheiser
(b) Address 2016 Ellsworth St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 14 (day) -46 (year)
(c) Cemetery or crematory Oak Hill Cem
Location Balto. Md.
18 (a) Funeral director John C. Miller Inc
(b) Address 2432 E. Oliver St
(c) Date received OCT 13 1946 (month) (day) (year) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/46 19 , at M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1946, to 10/10 1946 and that I last saw h[illegible] alive on 10/10 1946

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Tuberculous Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John B. Wells
Address 16 Jos Ury Date signed 10 10 46 M. D.

VS 150

G11517 BALTIMORE CITY HEALTH DEPARTMENT G11517
BC# 968193 CERTIFICATE OF DEATH 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 N. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos 28 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 W Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Roger Hayes~~ Roger Leon Hayes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1946

8. AGE: Years	Months	Days	If less than one day
	6	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard G. Hayes
13. Birthplace Masontown, W. Va.

MOTHER
14. Maiden Name Edith L. Turner
15. Birthplace Moorefield W. Va.

16 (a) Informant Howard G. Hayes
(b) Address 1006 N. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15 1946 (month) (day) (year)
(c) Cemetery or crematory Camp Hill Cem.
Location Balt. Co. Md.

18 (a) Funeral director Miller Carroll
(b) Address 510 Lexington Hyde Park
(c) Date rec'd by local reg. (b) Signature Livingston Williams, Registrar

OCT 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1946, to Oct 13 1946, and that I last saw him alive on Oct 12 1946.

Immediate cause of death Pneumonia Lobar.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Siracusa M. D.
Address 1729 W Fayette St Date signed 10/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44518 Registered No. 122 C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Lansthicum Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Hawthorne Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver B. Ward

3 (b) If veteran, name war: 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Annabell Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1874

8. AGE: Years	Months	Days	If less than one day
72 7	4	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired Farmer
11. Industry or business

FATHER
12. Name Emory Ward.
13. Birthplace Md

MOTHER
14. Maiden Name [redacted]
15. Birthplace Ann Hardesty Md.

16 (a) Informant Mr Wm E Ward
(b) Address 117 Edgevale Rd (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14-46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem
Location Washington Blvd.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St - 23

19 (a) [illegible] (b) (Date rec'd by registrar) Registrar

VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1946, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1946 to 10/10 1946, and that I last saw h. alive on 10/10 1946.

Immediate cause of death	Duration
Cardiac failure	
pesitonitis	
Due to operative procedure	
to correct volvulus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/7
Major findings of operation: volvulus
of autopsy: [redacted] Pendleton

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature F. Mitchell M.D.
Address Md. Gen Hosp Date signed 10/10/46

G14519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √52

G14519 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1533 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora E. Barry

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John
6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1865

8. AGE: Years	Months	Days	If less than one day
81	7	15	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Cornelius Crowley
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Sullivan
15. Birthplace Ireland

16 (a) Informant Mrs Margaret Nolan
(b) Address 338 E. 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Gorman & Son
(b) Address 1403 W. Pratt St

19 (a) Date received OCT 13 1946 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/1946 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1946 to Oct 11 1946 and that I last saw h[illegible] alive on Oct 11, 1946.

Immediate cause of death
Cerebral Embolism
Due to Coronary Occlusion
Due to Arteriosclerosis
Due to
Other Conditions

Duration
1 hr.
6 yrs.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specific type of place)
(e) Means of injury
23. Signature Chas. Morton Jr.
Address 1933 W. Baltimore St Date signed 10/14/46 M.D.

VS 150

G11520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G11520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 W. Fairmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 W. Fairmont Ave (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Judick

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 185-09-4614B

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard H. Judick
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 7, 1881

8. AGE: Years	Months	Days	If less than one day
65	6	7	hr. min.

9. Birthplace Philadelphia Pa. (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Leite
13. Birthplace Penn.

MOTHER
14. Maiden Name Louise Von Steffen
15. Birthplace Penn.

16 (a) Informant R. Linden Judick
(b) Address 2509 W. Fairmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

OCT 14 1946 (Date received by registrar) Huntington Williams M.D.

VS.186

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1946. at 6:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 10 1946 to Oct. 11, 1946. and that I last saw h.r alive on Oct. 11, 1946

Immediate cause of death: Congestive heart failure — Duration 11 Days.
Due to: High blood pressure — 6 years
Due to: Auricular fibrillation — 6 years
Other Conditions: Arteriosclerosis — 15 years.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert E. Rudman M. D.
Address 2517 W. Balto. St. Date signed Oct. 11, 1946

G41521 P.C. 9-59412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G41521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward James Appling Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Babe

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1546

8. AGE: Years	Months	Days	If less than one day
—	—	4	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Babe

11. Industry or business

FATHER
12. Name Edward James Appling
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Helen Koch
15. Birthplace Towson, Md.

16 (a) Informant Edward J. Appling
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

19 OCT 14 1946 (Date received by local registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1946, at 2:25 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1946, to Oct 12 1946, and that I last saw h.e alive on Oct 12 1946

Immediate cause of death Intracranial hemorrhage — Duration

Due to Birth injury

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 10/12/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write t

11522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

Registered No. GA 1522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (years ~~months~~ days) 37
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Falston.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Rutledge.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 6, 1878.
8. AGE: Years 67 Months 10 Days 7 If less than one day hr. min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Nurse - Registered
11. Industry or business
FATHER 12. Name Dr. Charles Rutledge
13. Birthplace Maryland
MOTHER 14. Maiden Name Elizabeth Hanway
15. Birthplace Maryland.
16 (a) Informant Charles Rutledge
(b) Address Fallston Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 46 (month) (day) (year)
(c) Cemetery or crematory St James
Location Monkton
18 (a) Funeral director Monkton Supply
(b) Address Jarrettsville Md
19 (a) Oct 14 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-13 1946, at 1:00 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1946 to Oct. 13 1946, and that I last saw h~~er~~ alive on ~~Oct~~ 13 Oct 1946.

Immediate cause of death: Carcinoma of Ovary Uterus — Duration
Due to McPartlan
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward H Jones Jr.
Address Union Mem. Hosp. Date signed 10-15-46
33rd & Calvert St. Balt. Md.

VS 150

G41523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G41523

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 9 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. GAY ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Lloyd Grady

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWED

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 16, 1880

8. AGE: Years	Months	Days	If less than one day
66	1	26	hr. — min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

MOTHER / FATHER

12. Name JOHN GRADY.
13. Birthplace VIRGINIA
14. Maiden Name MARY LIPTRAP
15. Birthplace VIRGINIA

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/13/46 (month) (day) (year)
(c) Cemetery or crematory
Location Winchester, Va.

18 (a) Funeral director Wm. J. Treiman & Sons
(b) Address No. 4 Pa. Ave. Balt. 17, Md.

19 OCT 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1946, at 6 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 16 1946, to OCT 11 1946, and that I last saw him alive on 10-11 1946.

Immediate cause of death CARDIO-VASCULAIR COLLAPSE.

Due to CARCINOMA WITH METASTASIS.

Due to —

Other Conditions CARCINOMA OF ESOPHAGUS.

(Include pregnancy within 3 months of death)

Date of operation 10-2-46.

Major findings of operation: GASTROSTOMY PERFORMED.

of autopsy: NOT DONE.

Duration
1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jarrad A. Roberts M. D.
Address Mercy Hospital Date signed 10-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C 11521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 11524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2120 Mura St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Mura St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Alfred Bigelow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Grace (Gage)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20, 1873

8. AGE: Years	Months	Days	If less than one day
73	7	23	hr. min.

9. Birthplace Kent County, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name John W. Bigelow
13. Birthplace Md

MOTHER
14. Maiden Name Towlson
15. Birthplace Md

16 (a) Informant Mrs Grace Bigelow
(b) Address 2120 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 '46 (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Kent County Md

18 (a) Funeral director Harry H Wilhelm
(b) Address 4101 Edmondson Ave

OCT 14 1946 (Date rec'd by registrar) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1946; at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1946 to Oct. 13 1946, and that I last saw him alive on Oct. 13 1946.

Immediate cause of death	Duration
Broncho pneumonia (bilateral)	3-5 days
Arteriosclerotic C.V. Disease	10 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Karl Grossman M. D.
Address 1212 N. Potters Ave Date signed 10/15/46

D. Karl Grossman M.D. Ave

G14525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G14525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dat
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Fowler

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Sally

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1882

8. AGE: Years	Months	Days	If less than one day
64 64	0	N	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER 12. Name Samuel L Fowler
13. Birthplace Md

MOTHER 14. Maiden Name Johanna Short
15. Birthplace Germany

16 (a) Informant Lonny Harvey
(b) Address 1st Lansdowne Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Fullerton Co Inc
(b) Address 1219 E Cold St

19 (a) OCT 14 1946 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1946, at 4:30 P.M

21. I certify that I took charge of the remains described above, held an ~~Inspection or Inquiry~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mahoney M.D. Medical Examiner.
Date signed 10-12-46

G44526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Harrisburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Melrose St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Reed B. Free

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Katherine Free
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) Sept 30 1888

8. AGE: Years	Months	Days	If less than one day
58	—	12	hr. min.

9. Birthplace Marysville Pa (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business Penna RR

FATHER
12. Name Charles H Free
13. Birthplace Illinois

MOTHER
14. Maiden Name Amanda Kruk
15. Birthplace

16 (a) Informant Alice Gondy
(b) Address 2509 N Charles St
17 (a) Final (Burial, cremation, or removal) (b) Date thereof 10/16/46 (month) (day) (year)
(c) Cemetery or crematory Lutherville
Location Lutherville Md
18 (a) Funeral director Wilson & Son Inc
(b) Address 1219 St Paul St.
(a) OCT 14 1946 Huntington Williams MD (Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1946 at 8:45 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Hypertensive C.V Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 10/13/46

VS 151

G44527

AB-75402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G44527 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs-2mos. 25days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 366 Marydell Road
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony (Pendergast) Prendergast

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19-1862

8. AGE: Years	Months	Days	If less than one day
84	6	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

FATHER
12. Name Anthony Prendergast
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Welch
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Loyola Catholic
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E. Oliver St.
(c) Filed OCT 14 1946 Huntington Williams M.D.
(Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12- 1946, at 8.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 46 to 10-12 1946, and that I last saw h alive on 10-12 1946

Immediate cause of death Hemopericardium with Tamponade — Duration 5 minutes

Due to Myocardial Infarction — Duration ? (Hours, days, 12 hrs.)

Due to Arteriosclerotic Cardiovascular Disease — Duration 10 years

Other Conditions Pulmonary Tuberculosis, far advanced; Latent Syphilis — Duration 15 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy Hemopericardium 250 cc. blood; infarct left ventricle and tuberculosis, pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Bird M. D.
Address Balto City Hosps Date signed 10-12-46

VS 150

937

G44528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G44528

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S.Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore, ~~Xxx~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N.Payson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ziegler, Horace T.

3 (b) If veteran, name war: SAW
3 (c) Social Security Account No. - - - -

4. Sex: m
5. Color or race: wh
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife - - - -
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept.30,1867

8. AGE: Years	Months	Days	If less than one day
79	0	12	hr. ____ min.

9. Birthplace Baltimore,Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business ----

FATHER
12. Name Joseph Ziegler
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Emma Ayler
15. Birthplace Baltimore,Maryland

16 (a) Informant Records
(b) Address U.S.Marine Hospital

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Oct 15-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director J.Pierpoint Corkran
(b) Address 217 E. Saint Paul Street

19 OCT 14 1946 (Date rec'd by local reg.) (b) Huntington Williams, M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1946 at 6:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept.18 1946 to Oct.12 1946, and that I last saw him alive on ~~Xxx~~ Oct.12 1946

Immediate cause of death: Carcinoma of the Urinary bladder — Duration: Unknown

Due to

Due to

Other Conditions Ulcerative cystitis with pyelonephritis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edson Chisolm, Surg. Balto., Md.
Address U.S.Marine Hospital, Date signed 10/12/46 M.D.

bs X

G44529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44529 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 Tolna St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Tolna St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Weber

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Anthony C. Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28 1883

8. AGE: Years	Months	Days	If less than one day
63	10	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Manicurist
11. Industry or business

FATHER
12. Name George A. Hubbard
13. Birthplace Rudau, Connecticut

MOTHER
14. Maiden Name Sarah E. McCleary
15. Birthplace Baltimore Md.

16 (a) Informant Anthony C. Weber
(b) Address 512 Tolna St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road
18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

Oct 14 1946 Interred by Williams M.B. (Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1946, at 6 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1946, to Oct 11 1946, and that I last saw h[illegible] alive on Oct 11 1946.

Immediate cause of death — Duration

Cardiac Asthma. — 2 hours
Due to Hypertension — 3 yrs.
Arteriosclerosis — 3 yrs.
Due to Cerebral Hemorrhage — 24 hr.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Braun M. D.
Address 1202 St Paul St Date signed 10/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G14530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G14530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Mulberry st. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Mathews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	N	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1889

8. AGE: Years	Months	Days	If less than one day
57	04	05	hr. min.

9. Birthplace St. Mary's County, Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucy Thomas
15. Birthplace Maryland

16 (a) Informant Pearl Knowles
(b) Address 630 Glenwillow St.

17 (a) Burial (b) Date thereof 10/15/46
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

OCT 14 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1946 at 6:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1946 to 10/10 1946 and that I last saw her alive on 10/10 1946.

Immediate cause of death: CHD. Congestive Heart failure — Duration 3 yrs.

Due to Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Carr M. D.
Address 515 Mosher St Date signed 10-11-46

D.C. J. 67533
G14531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161c

Registered No. G14531

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or Institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (Boundary)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Jack St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Moranica

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-46

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Chester Moranica
13. Birthplace Maine

MOTHER
14. Maiden Name Mary Elliott
15. Birthplace Penna

16 (a) Informant Mary Moranica
(b) Address 835 Jack St —

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-14-46 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director Joseph Farley
(b) Address Fulton & Fayette

19 (a) (Date rec'd) OCT 11 1946 (b) Huntington Pathological Laboratory

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1946, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1946 to 10-13 1946 and that I last saw her alive on 10-13 1946.

Immediate cause of death Rh Toxicity — Duration

Due to Erythroblastosis Fetalis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Leary K. Riggs MD M. D.
Address Union Hosp Date signed 10-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G44532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G44532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski
(c) Hospital or institution: Bon Secours Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Tremont Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Knight

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4 1882

8. AGE: Years 64 | Months 1 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Wife

11. Industry or business

FATHER
12. Name Patrick Norton
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Boylan
15. Birthplace Ireland

16 (a) Informant Frank J. Knight
(b) Address 13 Tremont Ave Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

19 (a) (Date received by registrar) OCT 14 1946 (b) Huntington Wilkinson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1946, to Oct. 13 1946, and that I last saw her alive on Oct 12 1946.

Immediate cause of death	Duration
Coronary Occlusion	Instantaneous
Due to Hypertensive C-V Disease	
Due to	
Other Conditions Diabetes Mellitus	13 yrs.

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp, Balto Date signed 10-13-46

937

G14533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1737

G14533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 nd. + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 Mt. Royal Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Wille S. Chamberlain

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: Mrs. Wille S. Chamberlain
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.) March 29, 1865

8. AGE: Years 81 | Months 6 | Days 12/14 | If less than one day: hr. min.

9. Birthplace Oraclin Ohio (Town, county, and state)
10. Usual Occupation College Professor
11. Industry or business Profession

FATHER
12. Name Edsel Chamberlain (D)
13. Birthplace ? Ohio

MOTHER
14. Maiden Name Mary Ellen Spencer
15. Birthplace ? Ohio

16 (a) Informant: Union Memorial Hospital Records
(b) Address 22nd + Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery Druid Ridge Cem. Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves Balto. Md.

19 (a) OCT 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1946, at 2 47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1946 to Oct. 12 1946, and that I last saw him alive on Oct. 12 1946.

Immediate cause of death: Severe Anemia — Duration:
Due to: Undetermined Cause
Due to:
Other Conditions: Terminal Cardiac Failure of short duration
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature A. L. Steele, M.D. M. D.
Address Union Memorial Hospital Date signed 10/14/46

X

G44531

G44531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 Washburn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Washburn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA M. SANFORD

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William J. Sanford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1890

8. AGE: Years 55 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Groff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William J. Sanford
(b) Address 202 Washburn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1946, at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1946 to Oct. 11 1946 and that I last saw h[illegible] alive on Oct. 11 1946.

Immediate cause of death: Carcinoma of the Urinary Tract — Duration: 3 Mo.
Due to
Due to
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. J. Gunnalds, M.D.
Address 1609 Gor. Rukins Hosp. Date signed 10-12-46

VS 150

G 24535 P.C. J-59313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 161a

Registered No. G24535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl FRANCIS - Doris Jean Francis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: femal | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-46

8. AGE: Years | Months | Days: 2 | If less than one day: 19 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William Francis
13. Birthplace " " "

MOTHER — 14. Maiden Name Lillian Perry
15. Birthplace " " "

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 10-14-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location W North ave

18 (a) Funeral director Lombardo Mortuary
(b) Address 414 N Broadway

OCT 14 1945 (Date received by registrar) (By) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1946, at 5-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12- 1946 to 10-13- 1946, and that I last saw h alive on 10-13- 1946.

Immediate cause of death: Cong. Atelectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature Eugenia Doyle M.D. M. D.
Address Date signed

VS 150

G41536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G41536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 E. Baltimore St.
(c) Hospital or institution:

6-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Baltimore St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 E. Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa Culotta

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or ~~wife~~ Rosario Culotta
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) June 12 1870

8. AGE: Years	Months	Days	If less than one day
76	3	29	hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

MOTHER | FATHER
12. Name Giovanni Culotta
13. Birthplace Italy
14. Maiden Name Concetta Di Marco
15. Birthplace Italy

16 (a) Informant Rosario Culotta (Husband)
(b) Address 1502 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15 1946 (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ Holy Redeemer St.
Location Belair Rd. Balt. Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

OCT 14 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11, 1946 to Oct. 11, 1946, and that I last saw h~~e~~r alive on Oct. 11, 1946.

Immediate cause of death	Duration
Myocarditis (Chronic)	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Passano M. D.
Address 514 Drury Lane Date signed 10/12/46

G44537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46E

G44537 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 UNIVERSITY PARKWAY
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME LILLIAN (NMI) HILLEGEIST

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	WHITE	W: DOWED

6 (b) Name of husband or wife WILLARD M. HILLEGEIST
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 29 NOV. 1889

8. AGE: Years	Months	Days	If less than one day
56 57	10	18	hr. min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name EDWIN H HEATH
13. Birthplace ENGLAND

MOTHER
14. Maiden Name SARAH REID
15. Birthplace BALTIMORE MARYLAND

16 (a) Informant MRS LILLIAN HILLEGEIST
(b) Address 909 UNIVERSITY PARKWAY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) OCT 14 1946 (b) Huntington Nelligan, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 OCTOBER 1946, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 AUG 1946, to 12 OCT. 1946, and that I last saw her alive on 10 OCT. 1946

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to CARCINOMATOSIS	+ 15 Mo.
Due to ADENOCARCINOMA OF TRANSVERSE COLON	+ 15 Mo.
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred B. Eyer, Jr. M. D.
Address Women's Hospital Date signed 12 Oct 46

X

G44538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G44538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 N. Monroe St
(c) Hospital or institution:
V°
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bruno Koenuh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1870

8. AGE: Years 76 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Tempfer Cans

FATHER
12. Name Edward Koenuh
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Berger
15. Birthplace Germany

16 (a) Informant Mrs Johanna Dees
(b) Address 322 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Fayette St

18 (a) Funeral director Harry H Wright
(b) Address 4101 Edmondson Ave

19 (a) OCT 14 1946 Registrar's signature Huntington Hall Cemetery, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1940, to Oct. 11 1946, and that I last saw him alive on Oct. 10 1946.

Immediate cause of death Hypertensive cardio vascular disease — Duration 6 yrs 7 mos.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitch M. D.
Address 1226 Hanover St Date signed 10/12/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN. G14539 105122 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G14539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Hillen St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21 1884

8. AGE: Years	Months	Days	If less than one day
61	9	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary
15. Birthplace Maryland

16 (a) Informant Mary R. Dudley
(b) Address 1334 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn, Maryland

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St

19 (a) (b)
(Signature and title of registrar) Registrar

OCT 14 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10th 1946 19 at 9.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9th 1946 to Oct 10 1946 and that I last saw h im alive on Oct 10 1946

Immediate cause of death	Duration
Respiratory Failure	7
Due to Syphilitic Heart Disease.	1
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Syphilitic Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edmund D. Beasham M.D.
Address Balto City Hosp. Date signed 10-14-46

OS-150

G14510 G14510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 2.5th St
(c) Hospital or institution: Sp Dents Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy M. Krug

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank W. Krug
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 3 1896

8. AGE: Years	Months	Days	If less than one day
50	5	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife -
11. Industry or business

FATHER
12. Name August Knight -
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine (?)
15. Birthplace Md.

16 (a) Informant Frank W. Krug (Husband)
(b) Address 1725 S. Charles St Balto 30 Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct. 14 46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location B.C. Co., Md.

18 (a) Funeral director J. Bernard Evans
(b) Address 1405 S. Charles St, Balto 30 Md

19 (a) [illegible] Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11-1946 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1946 to 10-11 1946 and that I last saw h SR alive on 10-11 1946

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Hypertension	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 120 Light St Date signed

VS 150

X 10-11-46

G11511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G11511 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 Division St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Diggs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Diggs
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Earl Diggs
(b) Address 729 Arundell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George D. Nelson
(b) Address 1303 Presstman St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 14 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1946, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1946, to Oct 11, 1946, and that I last saw him alive on Oct 10, 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2445 W. Hill Av. Date signed 10-14-46

X

G11542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G11542

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph LARKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widow

6 (b) Name of husband or wife Bertha B. Larkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Frederick Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Edna Robinson
(b) Address 1135 Brewer St.

17 (a) Burial (b) Date thereof Oct. 15, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location

18 (a) Funeral director Mrs Kettie A Williams
(b) Address 332 S. Schroeder St.

19 (a) Oct 14 1946 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/46 19 at 3:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C Davis M.D.
Medical Examiner.
Date signed 10/11/46

CHANGE MADE IN ENTRIES MUST BE INITIALED BY PERSON MAKING THE CHANGE. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 137a

G44513
Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Milbern Ave
(c) Hospital or institution: St Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Hammonds Ferry Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Reid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-1884

8. AGE: Years	Months	Days	If less than one day
62	2	29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Deceased
13. Birthplace Germany

MOTHER
14. Maiden Name Deceased
15. Birthplace Md.

16 (a) Informant CHARLES BARBEE.
(b) Address 224 ELIZABETH AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10, 16, 46 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK.
Location FREDERICK AVE

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) OCT 14 1946 (Date received by registrar) (b) Registrar
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1946 to Oct. 13 1946. and that I last saw h alive on Oct. 13 1946

Immediate cause of death	Duration
Pulmonary embolism	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 7, 1946
Major findings of operation: Pernicious anaemia. B.H.P.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Garrison, M.D.
Address St. Agnes Hosp Date signed 10/17/46

G14541 G14544

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6802 Beech Ave
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Pfeifer ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Jacob L. Pfeifer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/7/1877

8. AGE: Years	Months	Days	If less than one day
69	7	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Snyder
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Tremper
15. Birthplace Balto. Co. Md

16 (a) Informant Mrs. Emma Dresch
(b) Address 6802 Beech Ave.

17 (a) Burial (b) Date thereof 10/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Balto. Co. Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Date received by local registrar Huntington Williams [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Oct. 1946, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Sept 1946, to 13 Oct 1946 and that I last saw h[illegible] alive on 13 Oct 1946.

Immediate cause of death	Duration
Lobar Pneumonia right lower lobe	
Due to	
Due to	
Other Conditions Carcinoma of gallbladder (Include pregnancy within 3 months of death)	

Date of operation 9-28-46
Major findings of operation: Carcinoma of Gallbladder
Autopsy? Pneumonia, right lower lobe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M. D.
Address St. Joseph's Date signed 10/17/46

X

G44545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G44545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 N. High St.
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 N. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew John Pessagno

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1881

8. AGE: Years	Months	Days	If less than one day
65	3	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Dominic J. Pessagno
13. Birthplace Italy

MOTHER
14. Maiden Name Filomena Poggi
15. Birthplace Italy

16 (a) Informant Dominic Pessagno
(b) Address 323 N. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles F. Evans & Son
(b) Address 118 West Mt. Royal Ave.

19 (a) OCT 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1946 at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1946 to Oct. 12 1946 and that I last saw him alive on Oct. 12 1946.

Immediate cause of death	Duration
Right ventricular heart failure	3 mos.
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph L. Valentine M.D.
Address 1732 E. Broadway Date signed Oct. 14 '46

393062 G44546 BALTIMORE CITY HEALTH DEPARTMENT G44546
CERTIFICATE OF DEATH 13B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Dock St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ollie Dudley
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-10-4630

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-?-77
8. AGE: Years 69 68 | Months 2 | Days | If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Street Cleaner
11. Industry or business
FATHER 12. Name Albert Dudley
13. Birthplace Va.
MOTHER 14. Maiden Name Maria ?
15. Birthplace Va.
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co. Md
18 (a) Funeral director Roberts & Williams
(b) Address 516 McElderry St
OCT 1 1946 (Date filed by Registrar) Livingston Williams

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct 9 1946, at 4:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946 to Oct 9 1946 and that I last saw him alive on Oct 9 1946.
Immediate cause of death PULMONARY TUBERCULOSIS — Duration NOT KNOWN
Due to
Due to
Other Conditions CHRONIC CONSTRICTIVE PERICARDITIS DUE TO TBC
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: MIDLAPSED TBC INVOLVING LUNGS, PERICARDIUM, LIVER.
of autopsy: CHRONIC CONSTRICTIVE PERICARDITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frances D Stephens M. D.
Address Johns Hopkins Hospital Date signed 10-10-46

VS 150

G44547 G44547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW P. BEHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife MARY M. Behan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1890

8. AGE: Years	Months	Days	If less than one day
56	7	14	hr. min.

9. Birthplace IRELAND (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Patrick Behan
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Lambert
15. Birthplace Ireland

16 (a) Informant Mrs Mary M. Behan
(b) Address 1503 E Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15, 1946 (month) (day) (year)

(c) Cemetery or crematory St Charles Church Cem
Location Pleasant Lane Pikesville Md

18 (a) Funeral director Edgar W Conklin Son
(b) Address 924 E Lafayette St

19 (a) (Date rec'd by registrar) (b) Registrar

VS OCT 14 1946 Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Oct. 1946 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-46 19 to 10-12-46 19 and that I last saw him alive on 10-11-46 19

Immediate cause of death Angina — Coronary Arterio-sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Wells M. D.
Address 18 Jos Hop Date signed 10-12 46

G14518 G14518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Southway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Cornelia Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1887

8. AGE: Years: 59 | Months: 1 | Days: | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Librarian

11. Industry or business

FATHER: 12. Name Herbaum Thomas
13. Birthplace Baltimore

MOTHER: 14. Maiden Name Rose Fiellenkamp
15. Birthplace Baltimore

16 (a) Informant: Miss. Cornelia Thomas
(b) Address (deceased)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Balto. City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Hgts.

19 (a) (Date received by registrar) (b) Registrar

OCT 14 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1946, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1946 to Oct. 11 1946, and that I last saw her alive on Oct. 11, 1946.

Immediate cause of death: Cardiac resp failure — Duration: 1 month

Due to: Lat-prothyroid hemorrhage — Duration: several years

Due to: Arteriosclerotic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard C. Conner M. D.
Address Mercy Hospital Date signed 10-11-46

G44549 BALTIMORE CITY HEALTH DEPARTMENT G44549
CERTIFICATE OF DEATH 1246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 D
(e) Length of stay in Baltimore (yrs., mos., or days) 26 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. FRONT ST.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country -------

3 (a) FULL NAME Alice Anna CARNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Carney
6 (c) If alive, give age 190? (1902)

7. Birth date of deceased (mo., day, yr.) Dec. 28, (1901)

8. AGE: Years 43 (44) Y. | Months 9 | Days 14 | If less than one day --hr. --min.

9. Birthplace: New York City
(Town, county, and state)

10. Usual Occupation: None
11. Industry or business: -----

FATHER
12. Name: Michael Meade
13. Birthplace: New York

MOTHER
14. Maiden Name: Margaret Campion
15. Birthplace: New York

16 (a) Informant: Miss Margaret R. Meade
(b) Address: King's Park, Long Island, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) OCT 14 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Portal cirrhosis of liver, with hemorrhage from ruptured Duo- esophageal varices.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause fill in the following:
(a) Date of injury ---- at ---- M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George B. Merrill M.D.
Medical Examiner.
Date signed 10/14/46

VS 181

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G44550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44550 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 2603 Hampden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Hampden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Hubbard

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
I World War	No	M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22-1890

8. AGE: Years	Months	Days	If less than one day
55 57	9	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John R Hubbard
13. Birthplace unknown

MOTHER
14. Maiden Name Margaret Troy
15. Birthplace unknown

16 (a) Informant Thalmadge Hubbard
(b) Address 2914 Edmondson Rd

17 (a) Burial (b) Date thereof 10-15-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md

18 (a) Funeral director Frank H Seel
(b) Address 734 736 Sh

OCT 14 1946
(Date rec'd by registrar) (b) Huntington Williams Jr M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1946, at 2:24 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. C. Tubman M.D.
Medical Examiner.
Date signed 10/20/46

X

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G14551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G14551.1

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 848 1/2 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mary Konezis ✓

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	married

6 (b) Name of husband or wife Francis Konezis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1st 1895

8. AGE: Years	Months	Days	If less than one day
50	11	12	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name Unknown
13. Birthplace Lithuania

MOTHER
14. Maiden Name Unknown
15. Birthplace Lithuania

16 (a) Informant Mrs May B. Bartasavich
(b) Address 848 1/2 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-07 Hollins St.

19 (a) Date received (Registrar) (b) Registrar

OCT 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1946 at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1946 to Oct 13 1946, and that I last saw h[illegible] alive on Oct 13 1946

Immediate cause of death Pneumonia — Duration

Due to Cardiac Failure

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel D. Daly M. D.
Address Sinai Hospital Date signed 10/17/46

X

Ringer
-G11553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V106B

G11553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4412 Belvieu Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4412 Belvieu Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KANSAS E. RINGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah A. Ringer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26, 1872

8. AGE: Years	Months	Days	If less than one day
74	5	17	hr. min.

9. Birthplace Boonesboro, Md. (Town, county, and state)
10. Usual Occupation -retired
11. Industry or business

FATHER
12. Name Isiah Ringer
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Sarah A. Ringer
(b) Address 4412 Belvieu Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15.46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Wilson Registrar

VS 150 OCT 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13- 1946, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 1945 to 10-13 1946 and that I last saw [illegible] alive on 10-12- 1946.

Immediate cause of death	Duration
Acute dilatation of heart	1 day
Due to Arteriosclerosis	10 yrs.
Due to Hypertension	10 yrs.
Other Conditions Bronchiectasis	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address 220 W Read Date signed 10-13-46 M. D.

Sigmar Pirosh X

G41553 — BALTIMORE CITY HEALTH DEPARTMENT — G41553 Registered No.

CERTIFICATE OF DEATH V 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 N. Calvert St.
(c) Hospital or institution: H
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES BROWN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Maclachlen Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1861

8. AGE: Years	Months	Days	If less than one day
85	5	5	hr. min.

9. Birthplace Edinborough, Scotland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Cunningham
13. Birthplace Scotland

MOTHER
14. Maiden Name Jane -
15. Birthplace Scotland

16 (a) Informant Mr. J. M. Brown
(b) Address 910 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 14 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1946, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1946 to Oct 12 1946 and that I last saw h[illegible] alive on Oct 12 1946.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arterio-sclerosis	
Due to Chronic myocarditis	
Due to Chronic Nephritis	
Other Conditions Complete Prolapse of uterus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wesley A Anderson M. D.
Address 300 Lennox Drive Date signed Oct 14-46

VS 150

G11551 G11551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2030 Mt. Royal Terr.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 Mt. Royal Terr. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA MAY CHAMBERLAIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wilbur S. Chamberlain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1866

8. AGE: Years	Months	Days	If less than one day
79	9	24	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Walker
13. Birthplace England

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Mr. H. B. Chamberlain, son
(b) Address 139 N. Arlington Ave., East Orange, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1946 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1946 to Oct. 13 1946 and that I last saw her alive on Oct. 12 1946

Immediate cause of death	Duration
Myocardial Insufficiency	?
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Thompson M. D.
Address 1109 St Paul St signed 10-14-46

VS 150

OCT 14 1946

Huntington Williams, M.D.

40 P.D.
G24555
H.S. Disp.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓159

Registered No. G24555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Lombard Court. Victory Villa
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kohajda

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1946

8. AGE: Years	Months	Days	If less than one day
*		1	hr. min.

9. Birthplace Essex, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Matthew G. Kohajda
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Julia M. Theis
15. Birthplace Balto. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Md.

18 (a) Funeral director Henry Sanders Sons, Inc.
(b) Address North Ave & Broadway

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 14 1946 Huntington Hill Station, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1946 at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1946 to Oct. 13 1946, and that I last saw him alive on Oct. 13 1946.

Immediate cause of death ? asphyxiation — Duration

Due to —

Due to —

Other Conditions premature infant

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Sheldon
Address Date signed 10/13/46

Howard J. Sheldon, M.D.

G14556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G14556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 N 36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T Proctor
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 - 186

8. AGE: Years	Months	Days	If less than one day
80 79	3	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Joseph Proctor
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Price
15. Birthplace Md

16 (a) Informant Miss Mildred Jones
(b) Address 818 N 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 16 46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 36th St

19 (a) OCT 16 1946 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1946, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1946, to Oct 13 1946 and that I last saw her alive on Oct 13 1946.

Immediate cause of death	Duration
(a) Arteriosclerotic Cardiovascular disease	?
Due to Heart failure	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wollenstein M. D.
Address 818 N 36th St Date signed 10/14/46

VS 150

Registrar Williams, MD

G14557 BC# G34112 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 180 Registered No. G14557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1757 Jefferson Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANN DENTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/45

8. AGE: Years 1 | Months - | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER 12. Name William Denton

13. Birthplace S.C

MOTHER 14. Maiden Name Azella V. Williams

15. Birthplace N.C.

16 (a) Informant William Denton

(b) Address 1757 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location

18 (a) Funeral director Leroy O Wilson

(b) Address 1000 E Fayette St

19 (a) 10-14-1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/46, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 2° & 3° burns, head & extremities

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/12/46 at 6:15 P.M.
(b) Where did injury occur? 1757 Jefferson St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire

23. Signature John L Evans M.D. Medical Examiner.
Date signed 10/17/46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G14558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G14558 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write, the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2626 Boone St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Boone St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. McNorton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex W.

5. Color or race C

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Annabell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Chatham Va (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Frank W. McNorton
13. Birthplace Chatham Va.

MOTHER
14. Maiden Name Lucy
15. Birthplace Chatham Va

16 (a) Informant Garland Brown
(b) Address 2626 Boone St

17 (a) Disposition Buried (Burial, cremation, or removal) (b) Date thereof Oct. 14 1946 (month) (day) (year)
(c) Cemetery or crematory Chatham Va
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Date received OCT 14 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12-46 19 at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1946 to 10-12-46 19
and that I last saw him alive on 10-11-46 19

Immediate cause of death Hypertension Cardio Renal Disease

Due to

Due to

Other Conditions Diverticulosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration 1 yr ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Abrams, M.D.
Address 312 E 23rd St Date signed 10/47

C41559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

Registered No. C41559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Enson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Tisdale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1916

8. AGE: Years 29 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Pitchough Tisdale
13. Birthplace Va

MOTHER
14. Maiden Name Eva Phillips
15. Birthplace Va

16 (a) Informant Elizabeth Tisdale
(b) Address 505 N. Enson St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-16-46 (month) (day) (year)
(c) Cemetery or crematory
Location South Hill, Va

18 (a) Funeral director Joseph E. Locke
(b) Address 1364 N. Central Ave

(c) Date received by Registrar OCT 15 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION 42

20. DATE OF DEATH October 13, 1946, at 10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of the thigh involving the femoral artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-46 at 8 P. M.
(b) Where did injury occur? Forrest & Orleans Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury. Firearms

23. Signature Howard J. Mahoney M.D. Medical Examiner.
Date signed 10-14-46

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G11560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G11560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — BUREN ST.
(b) Street address 801 Buren St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 N. Bond St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME (Robert Borden) Robert W. Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	col	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER
12. Name Warren Boyd
13. Birthplace N. C.

MOTHER
14. Maiden Name Martha Leathers
15. Birthplace N. C.

16 (a) Informant Geraldine Gillam
(b) Address 1618 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1307 N. Central Ave

19 (a) OCT 15 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1946, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1946, to 10/13 1946, and that I last saw him alive on Oct 12 1946.

Immediate cause of death: Aortic insufficiency — Duration: Unknown

Due to

Due to

Other Conditions Myocardial failure.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. MacMurchy M.D.
Address 801 Buren St. Date signed 10/14/46

G11561

AB- 104025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G11561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo- 17days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Malinowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-3123

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3- 1890

8. AGE: Years	Months	Days	If less than one day
55	10	8	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Moulder
11. Industry or business Westinghouse

FATHER
12. Name Alexander Malinowski
13. Birthplace Poland

MOTHER
14. Maiden Name Amelia Roda or Amelia Rhode
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director Marie E. Fiakowski
(b) Address 10003 Kenwood Ave

19 Oct 15 1946 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1946, at 2.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1946 to 10-11 1946 and that I last saw h im alive on 10-11 1946.

Immediate cause of death Probable Bronchogenic Carcinoma — Duration 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 10-11-46

X

G11562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G11562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Bolton St., (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baker, Harry C

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Manabelle Baker (nee Almond)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1885

8. AGE: Years	Months	Days	If less than one day
61	6	29	hr. min.

9. Birthplace -- (Town, county, and state)
10. Usual Occupation Merchant Seaman
11. Industry or business Purser

FATHER
12. Name Henry Baker
13. Birthplace Maryland (Balto. Co.)

MOTHER
14. Maiden Name Margaret Trehena
15. Birthplace Virginia

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by local registrar) (b) Huntington Williams, M.D.

OCT 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 46 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 19 46 to Octo. 14 19 46, and that I last saw him alive on Oct. 14 19 46

Immediate cause of death	Duration
Infarction of myocardium due to arteriosclerotic coronary thrombosis.	
Due to	
Due to	
Other Conditions	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
Address Clinical Director Date signed 10/14/46

John L. Wilson, Sr. Surgeon, P.

G14563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G14563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1601 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Wachsman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name Isaac

13. Birthplace Poland

MOTHER 14. Maiden Name Esther

15. Birthplace Poland

16 (a) Informant Rose Wachsman

(b) Address 1601 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 16 (day) 46 (year)

(c) Cemetery or crematory Herring Run

Location Rd

18 (a) Funeral director Jack Cohen Inc

(b) Address 1437 E. Balto St

19 (a) OCT 15 1946 (Date rec'd by registrar) Huntington Woods, Mich. (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Oct 14 1946, and that I last saw him alive on Oct 11 1946

Immediate cause of death	Duration
Coronary thrombosis	
Due to Coronary Artery Disease	8 years
Due to Artery sclerosis	20 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack Cohen M.D.

Address 1804 Eutaw Place Date signed 10/14/46

X

G11561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G11561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Saffran

3 (b) If veteran, name war: N

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Julia M. Saffran

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1862

8. AGE: Years	Months	Days	If less than one day
84	7	22	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Conrad Saffran
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Alice
15. Birthplace: Germany

16 (a) Informant: Edward Saffron
(b) Address: 2712 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 17 46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Ave.

18 (a) Funeral director: Wm. Cook Sons
(b) Address: 1217 E. Paul St. Huntington for Hutchins, M.D.

19 (a) Registrar
(Date received by Registrar) OCT 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Oct. 8 1946, and that I last saw h[illegible] alive on Oct. 8 1946.

Immediate cause of death	Duration
(a) Cerebral Arterio Sclerosis -	
Due to Vascular Disease	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Clyde Loughlin M. D.
Address 400 N. Payson St. Date signed 10/15/46

Dr. C. MacLaughlin

G14565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G14565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 Whateoat St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town write RURAL and name county)
(d) Street No. 811 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 - 1916

8. AGE: Years	Months	Days	If less than one day
29 30	10	6	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Theodore Shaw
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rachel Green
15. Birthplace Balto Md

16 (a) Informant Williemeter Smith
(b) Address 811 Whateoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (b)
(Signature of local registrar) Registrar

OCT 18 1946
Huntington Williams, M.D.

Va 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1946, at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1946 to 10/14 1946
and that I last saw him alive on 10/14 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Rhetta M. D.

Address 24 39 Druid Hill Ave Date signed 10/15/46

X

G41566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G41566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Chapel gate Lane
(c) Hospital or institution: Pine Crest
(d) Length of stay in hospital or inst. (yrs., mos., ~~or days~~) 6 Mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Nathpoint Rd. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Baldridge Baldridge
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/1880

8. AGE: Years	Months	Days	If less than one day
66	4	18	hr. min.

9. Birthplace New Castle Pa (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace " "

16 (a) Informant Welfare Board
(b) Address Balto Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 (month) (day) (year)
(c) Cemetery or crematory Texas Farm
Location Texas Balto Co

18 (a) Funeral director Edgar S May Nabb
(b) Address Catonsville Md

OCT 15 1946 (Date received by registrar) Functioning for Williams M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1946, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Oct 1946 to 10/10 1946, and that I last saw h e alive on 10/10 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	10 dy
Due to Arterio-sclerosis	
Due to	
Other Conditions Senile dementia	1 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dayman Baldridge M. D.
Address 3376 Eastern Ave Date signed 10/14/46

X

G44567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44567 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Westwood ave 15
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Westwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Elizabeth Bond-nee-Molok

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	widow

6 (b) Name of husband or wife Winslow Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-28-1886

8. AGE: Years	Months	Days	If less than one day
59	11	12 15	hr. min.

9. Birthplace Owen sound - Ont. Canada
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Francis Molok
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Wilson
15. Birthplace Phila - Pa.

16 (a) Informant Marjorie Bond
(b) Address 1706 Westwood Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct-16-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Maryland

18 (a) Funeral director Mrs Dora Bailey
(b) Address 1421 E Jefferson st.

19 (a) OCT 15 1946 (Date received) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October-12 1946 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1946 to 10-12 1946, and that I last saw h e alive on 10-12 1946

Immediate cause of death: hypertensive cardio-vasculor disease — Duration: sev. yrs.

Due to:

Due to:

Other Conditions: arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1500 E-Madison St Date signed 10/14/46

Rayner Browne X

G41568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G41568 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ----
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 849 Lemmon Street, (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MEDLEY, Cornelius

3 (b) If veteran, name war: SAW

3 (c) Social Security Account No. - - - -

4. Sex: M | 5. Color or race: col | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife - - - -

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1885-month & day unknown

8. AGE: Years 85 | Months -- | Days -- | If less than one day ____ hr. ____ min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation None

11. Industry or business - - - -

MOTHER / FATHER

12. Name Unknown

13. Birthplace Unknown

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Records

(b) Address U.S.Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/46 - (month) (day) (year)

(c) Cemetery or crematory Baltimore National

Location Elroy O Wilson

18 (a) Funeral director

(b) Address 1000 Brantly ave

19 (a) ____ (b) ____ Registrar

OCT 15 1946

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct.11 1946, at 6:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1946, to Oct.11 1946, and that I last saw h im alive on Oct.11 1946.

Immediate cause of death: Diabetes mellitus with gangrene of rt. foot — Duration: unknown

Due to: ____ — Duration: ____

Due to: ____ — Duration: over

Other Conditions: Abscess pulmonary left lower lobe — Duration: 1 week

(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: As Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: ____

(b) Date of occurrence: ____ at ____ M

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)

(e) Means of injury: ____

23. Signature Marie Huston, M.D.

Address U. S. Marine Hosp Date signed 10/16/46

Baltimore, Md

Huntington Williams, M.D. bs

G21569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G21569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 St. Barnabas Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 St. Barnabas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Mencer - alias - (Louis Freeman)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-24-1906

8. AGE: Years 40 | Months 6 | Days 20 | If less than one day: hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Mencer
13. Birthplace Va

MOTHER
14. Maiden Name Cora Davis
15. Birthplace Va

16 (a) Informant Sage Mencer.
(b) Address 907 Lombard St. near Richmond Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 17 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 946 Penna ave Huntington-Williams, W Va

OCT 15 1946 (Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1946 to 10/13 1946; and that I last saw h[illegible] alive on Oct 13 1946.

Immediate cause of death: (a) Pneumonia
Due to: (b) Lobar Pneumonia
Due to: (c) Lung bump
Due to: (d) Suicidal by strychnine

Duration: 6 months

Due to: 2nd degree X-ray burns

Other Conditions: followed by infection

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1537 [illegible] Date signed 10/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Medical Certificate of Death

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 195E

Registered No. G11570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Alexandria (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Bashford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Eardley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-45

8. AGE: Years	Months	Days	If less than one day
1	8 7	22	hr. min.

9. Birthplace District of Columbia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Raymond Eardley.
13. Birthplace Pa

MOTHER 14. Maiden Name Maxine Freeman
15. Birthplace Pa

16 (a) Informant Ranch
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-15-46 (month) (day) (year)
(c) Cemetery or crematory
Location Alexandria, Virginia

18 (a) Funeral director Geo. J. Zirkenbach & Sons
(b) Address North & Fenna Ave Balto

19 (a) 1946 (Date rec'd by registrar) (b) Catherine Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14. 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1946, to Oct. 14 1946, and that I last saw him alive on Oct. 14 1946,

Immediate cause of death Strangulation

	Duration
Due to Large button in the right hypopharynx	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10/14/46 1 P.M.
(c) Where did injury occur? 913 Bashford Road (City or town) (Co.) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Swallowed a button

23. Signature Richard E. Dorrance, M.D.
Address Johns Hopkins Hosp. Date signed 10/15/46 M.D.

Howard J. Andersen, M.D.

VS 150

G11571 — BALTIMORE CITY HEALTH DEPARTMENT — G11571 Registered No.

CERTIFICATE OF DEATH ✓ 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Downs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Richard D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4-1880

8. AGE: Years	Months	Days	If less than one day
66	9	9	hrs. min.

9. Birthplace Odenton - Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name George Murray
13. Birthplace Cleveland

MOTHER
14. Maiden Name Emily Lowman
15. Birthplace D.

16 (a) Informant Carla A. Downs (adm)
(b) Address Linthicum Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/46 (month) (day) (year)
(c) Cemetery or crematory
Location Odenton Md.

18 (a) Funeral director Selby & Zeilenfelder
(b) Address 402 S. Abbey St

19 (a) (Date rec'd by registrar) (b) Huntington Md. (Registrar)

OCT 15 1946

VS-190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1946, at 12:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1946 to 10-13 1946, and that I last saw h[illegible] alive on 10-13 1946

Immediate cause of death: Cerebral hemorrhage — Duration

Due to hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Darby M. D.
Address Mercy Hosp. Date signed 10-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

O.D.A G11572 — BALTIMORE CITY HEALTH DEPARTMENT — G11572 Registered No.

Accident Room

CERTIFICATE OF DEATH 92 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Jarbuston

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-31-1894

8. AGE: Years	Months	Days	If less than one day
52	8	14	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Nagengast
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Albacker
15. Birthplace Germany

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Belair Rd.
18 (a) Funeral director Tully & Zachs
(b) Address 403 S. Wolfe St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-14-1946, at 10.16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946, to Oct 14 1946, and that I last saw h Mc alive on Oct 14 1946.

Immediate cause of death	Duration
Cerebral Embolism	30 min
Due to Auricular Fibrillation	#1 MD.
Due to Rheumatic Heart Disease with Mitral Stenosis	?
Other Conditions Idiopathic Epilepsy	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Williams
Address Johns Hopkins Hospital Date signed 10-14-46 M. D.

For D. Walter Hoffman, by Howard J. Tennison, M.D.

G44573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G44573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Huffman Sts
(c) Hospital or institution: St. Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead on arrival
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 643 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William P. Duffy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-03

8. AGE: Years	Months	Days	If less than one day hr.	min.
43	4 3	21		

9. Birthplace Youngstown Ohio (town, county, and state)

10. Usual Occupation
11. Industry or business Bethlehem Steel

MOTHER / FATHER
12. Name James Duffy
13. Birthplace Ohio
14. Maiden Name Barbara McGowan
15. Birthplace Ohio

16 (a) Informant Sister-in-Law.
(b) Address 643 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmonson Ave

18 (a) Funeral director Tully & Zeller Co
(b) Address 403 S. Wolfe.

19 (a) 5 1946 (b) Huntington Williams Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1946 at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 1946 to Oct 12 1946, and that I last saw him alive on Oct 12 1946.

Immediate cause of death	Duration
(a) Cardiac Failure	
Due to (b) Myocarditis. Cardiac Decompensation	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Flannigan M. D.
Address 3503 East Ave Date signed 10-12-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G14571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G14571

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 843 S.Kenwood Ave
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 843 S.Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Kowalewski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~XXX~~ John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1859

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Unknown
13. Birthplace Unknown

14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Michael Kowalewski
(b) Address 843 S.Kenwood Ave

17 (a) Burial (b) Date thereof 10/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) (Date received) (b) Registrar

OCT 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19th 1946, at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1946, to Oct 17 1946, and that I last saw h[illegible] alive on Oct. 14 1946.

Immediate cause of death Chronic Myocarditis

Due to Arteriosclerosis Cardiovascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Wolfe M. D.
Address 1331 E. Monument Ave Date signed 10-17-46

X

G14575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54 B

Registered No. G14575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 N. Augusta Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N. Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William R. Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1894

8. AGE: Years	Months	Days	If less than one day
51	10	21	hr. min.

9. Birthplace Sykesville, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charley Phoebus
13. Birthplace Mont. Co., Md.

MOTHER
14. Maiden Name Rosalie Miller
15. Birthplace Sykesville

16 (a) Informant William R. Jenkins
(b) Address 719 N. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director George Boyer
(b) Address 5005 Park Heights Ave.

19 OCT 15 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19__ to Oct. 1946, and that I last saw her alive on Oct. 19 46.

Immediate cause of death Brain tumor. — Duration Unknown

Due to — Duration over

Due to

Other Conditions None.

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation

of autopsy None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh Boyer, Jr. M. D.
Address 11 E. Chase St. Date signed 10.15.46

VS 150

Boyer X

G41576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G41576 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 Carswell St. Balto. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Henrietta Taber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. Clifford Taber

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1899

8. AGE: Years 47 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Mercy Conv. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Albert Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Wilhelmena Koehler
15. Birthplace Maryland

16 (a) Informant Clifford Taber
(b) Address 1639 Carswell St. Balto.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/16/46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mill

OCT 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1946, at 2:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13, 1946 to Oct. 14 1946, and that I last saw h[illegible] alive on Oct. 14 1946.

Immediate cause of death Coronary thrombosis — Duration 12 hours
Due to Acute Coronary thrombosis & secondary fibrosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Kramer M. D.
Address Mercy Hospital Date signed 10-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G11577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

137a

G11577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Stoakley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-90

8. AGE: Years	Months	Days	If less than one day
56	1	1	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Stoakley
13. Birthplace Va.

MOTHER
14. Maiden Name Emily Parker
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert Williams
(b) Address 1516 McElderry St

19 (a) (b) Registrar
Date Received 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946, at 3.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1946 to Oct 14 1946 and that I last saw him alive on Oct. 14 1946.

Immediate cause of death: Cardiac failure & Renal failure — Duration 3 days

Due to Arterio Sclerosis & Hypertension & diabetes Mellitus & Senility

Other Conditions

(Include pregnancy within three months of death)

Date of operation Oct. 6

Major findings of operation: B. P. N.

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specific type of place)
(e) Means of injury

23. Signature William E. Jenkins M.D.
Address Johns Hopkins Hosp. Date signed 14 Oct 46

VS 150

G11578 ✓ G11578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 Valley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine M. Stack

3 (b) If veteran, name war No — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James O. Stack — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1872

8. AGE: Years	Months	Days	If less than one day
74	2	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Candy Packer
11. Industry or business Confectionery

FATHER
12. Name Michael Huber
13. Birthplace Ireland

MOTHER
14. Maiden Name Emma Stanger
15. Birthplace Ireland

16 (a) Informant Mrs Mary Sweeney
(b) Address 1127 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat Cemetery
Location 5500 Frederick Rd

18 (a) Funeral director Elmer W. Conkle
(b) Address 924 E. Eager

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 15 1946 Lexington Millicent, M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946, to Oct 13 1946, and that I last saw alive on Oct 12 1946.

Immediate cause of death	Duration
(a) Hypertension Cardio-Vascular Renal Disease	9
Due to	1
Due to	
Other Conditions Coronary Thrombosis	6 wks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Sikorsky M. D.
Address 3930 Fr Valley St Date signed 10/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1579 BALTIMORE CITY HEALTH DEPARTMENT ✓ G21579

CERTIFICATE OF DEATH

169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city limits, write RURAL and name town)
(d) Street No. 308 Blk. W. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~UNKNOWN WHITE MALE~~ Payton S. Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1900

8. AGE: Years	Months	Days	If less than one day
46 (35-403)	1	3	hr. min.

9. Birthplace Moorefield, W.Va.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name William S. Fisher
13. Birthplace Moorefield, W.Va.

MOTHER 14. Maiden Name Mary Fisher
15. Birthplace Moorefield, W.Va.

16 (a) Informant Clarence H. Fisher
(b) Address Moorefield, W.Va.

17 (a) Removal (b) Date thereof 10/23/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Olivet Cem.
Location MOORFIELD WEST VIRGINIA

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

OCT 14 1946 Huntington, W. Va.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1946, at 7:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull; Intracranial hemorrhage; Petechial hemorrhages in the brain; Bloody cerebro-spinal fluid.

Due to

Other Conditions Fract. collar bone, ribs; Multiple abrasions and bruises. Also., multiple lacerations.
(Specify conditions, if any, contributing to death but not related to primary cause, and the interval between onset and death. Specify if conditions were chronic or of less than 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-25-46 at 16/4 M.
(b) Where did injury occur? Pulaski & Lanvale Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? P.R.R. Prop. While at work? No
(d) Means of injury Struck by Pa. R. R. Freightcar

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed

VS 181

G11580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1707

G11580 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Welsh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1-1925

8. AGE: Years	Months	Days	If less than one day
21	8	13	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Fred Welsh Jr
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Mary Brad
15. Birthplace Balto Co Md.

16 (a) Informant Mary Welsh
(b) Address 2510 Marine Ave.

17 (a) Burial (b) Date thereof (10 - 17 - 46)
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave

18 (a) Funeral director John C Miller Jr
(b) Address 243 E. Oliver St

19 (a) (b)
(Date received by registrar) Baltimore, Md.
OCT 15 1946 Hunting for Baltimore, Md

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1946, at 2 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rio death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage

Due to

Other Conditions Multiple fractures, lacerations brain, hand and bruises. Abd. puncture wound.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/4
(a) Date of injury 10-4-46 at A. M.
(b) Where did injury occur? North Pt. Rd. & Phila. Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Fell off moving motorcycle

23. Signature Howard J. Mckenzie M.D.
Medical Examiner.
Date signed 10/14/46

X

G11581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G11581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Chesterfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 3/4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lisette Huettner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Henry Huettner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12. 1875

8. AGE: Years	Months	Days	If less than one day
71	1	2	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Wm Koerner
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Kuster
15. Birthplace Germany

16 (a) Informant Mrs Elizabeth Kane
(b) Address 2811 Chesterfield Ave

17 (a) Burial (b) Date thereof Oct 17th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14th 1946 at 7:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1946 to Oct 14 1946, and that I last saw h e r alive on Oct 7 1946.

Immediate cause of death Cancer of intestines, Coast

Duration 7 1/2 mos (?)

Due to

Due to

Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation 9-1-46

Major findings of operation:

Extensive cancer of lower bowel with metastasis.

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Charles A. Sevcik M.D.
Address 4200 Parkwood Ave Date signed 10/15/46

Sevcik X

VS 480

OCT 15 1946

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G41582 — 170C — Registered No. G41582

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine T. Insogna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1921

8. AGE: Years	Months	Days	If less than one day
24	10	20	hr. min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Francesco Ceneli
13. Birthplace Italy

MOTHER
14. Maiden Name Frank Insogna
15. Birthplace Italy

16 (a) Informant Mrs. Pauline Halbert
(b) Address 1221 E. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 16- (month) (day) (year)
(c) Cemetery or crematory St Peters + Pauls Cem
Location Cumberland

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Data rec'd by registrar) (b) Huntington Williams, Registrar

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1946, at 12 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial Hemorrhage

Due to

Other Conditions Multiple fractures, laceration, bruises + bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-12-46 at 11:45 P. M.
(b) Where did injury occur? Old Annapolis Rd. Anne Arundel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian-auto into fixed object.

23. Signature Thomas J. Claggett M.D. Medical Examiner.
Date signed 10-15-46

X

BOH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1583 — 58252 — 159 — Reg. No. 11583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Spellman Road
(c) Hospital or institution: Home. 25
(d) Length of stay in Hospital or inst. (yrs., mos., or days) Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Newborn.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (Cherry Hill)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Spellman Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Battle

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-46 @ 5 A.M.

8. AGE: Years Newborn | Months Premature | Days Two Hrs 30 min. | If less than one day

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Cornelius Battle.
13. Birthplace Halifax N.C.

MOTHER
14. Maiden Name Mary McCraw
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Mary E. Battle
(b) Address 2705 Spellman Road

17 (a) City Morgue (Burial, cremation, or removal) (b) Date thereof 10-5-46 (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY OCT 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 15 1946 (Date filed by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5 1946, at 5:39 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 P.M. 5-10 1946 to 5:30 P.M. 5-10 1946, and that I last saw h[illegible] alive on 10-5 1946.

Immediate cause of death [illegible]
Atelectasis — Duration
Cardiac failure
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jenny E. Leach
Address 303 Ridgeview Date signed 10/5/46 M. D.

VS 150

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

Please write the causes of death clearly and legibly. Physicians: please write the underlying cause of death in the space provided. The correct age is especially important. Physicians: please write numbers and words, not abbreviations. Avoid using abbreviations or ditto marks. Typewriter supplies.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G 31581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby ? Dorothy Thornton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-46

8. AGE: Years	Months	Days	If less than one day
		23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otis Thornton
13. Birthplace Enfield N.C.

MOTHER
14. Maiden Name Dorothy Hayes
15. Birthplace Roanoke Va.

16 (a) Informant Dorothy Thornton
(b) Address 1017 Arlington Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY OCT 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 15 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-1946 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1946 to 10-8-1946 and that I last saw him alive on 10-8 1946.

Immediate cause of death

Due to Premature

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. Louise Jones M. D.
Address 1000 Druid Hill Ave. Date signed 10/10/46

VS 150

G11585 STRECKER ✓ G11585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Regester Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME OTTO T. STRECKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced? married

6 (b) Name of husband or wife Marie C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1886

8. AGE: Years 60 | Months 2 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Marie C. Strecker
(b) Address 812 Regester Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b) Date rec'd by registrar 15 1946 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 1946, at 8:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1946 to 10-14 1946, and that I last saw him alive on 10-14-1946

Immediate cause of death
Aortic tear
Due to dilatation
Due to Arterio Coronary occlusion
Due to of the Heart

Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wells M.D.
Address St Joseph Hosp Date signed 10/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.C.H. 7-39056

G11586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

G11586 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1214~~ Seidel Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Temple
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14, 1946

8. AGE: Years | Months | Days 2 | If less than one day 14 hrs min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation New born
11. Industry or business —

FATHER
12. Name John Temple
13. Birthplace Virginia

MOTHER
14. Maiden Name Evelyn Kendall
15. Birthplace Iowa

16 (a) Informant Chart (mother)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Huntington-Williams High (Date rec'd by Registrar) Registrar

OCT 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1946, at 9:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1946 to Oct 14 1946 and that I last saw h[illegible] alive on Oct 14 1946.

Immediate cause of death: Respiratory failure — Duration 3d

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lois F. Jordan M. D.
Address Church Home & Hospital Date signed Oct. 17, 1946

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G14587 P.L.G. 459462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

051 160a

Registered No. G14587

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Lewis Diggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/3/46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gustavius Diggs
13. Birthplace La.

MOTHER
14. Maiden Name Irene Butler
15. Birthplace N.J.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 15 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 6 - 1946 at 5-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4- 1946 to 10-6- 1946 and that I last saw deceased alive on 10-6- 1946

Immediate cause of death Respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to Birth injury

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Dorman M. D.
Address Johns Hopkins Hosp. Date signed 10/7/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G11588 Dec. 9-1946 BALTIMORE CITY HEALTH DEPARTMENT ✓ G11588
CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 757 Redwood St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl (B) Williams
3 (b) If veteran, name war NC
3 (c) Social Security Account No. No
4. Sex F
5. Color or race B
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife None
6 (c) If widowed, give age years
7. Birth date of deceased (mo., day, yr.) 10/11/46 - 11:56 AM
8. AGE: Years — Months — Days — If less than one day 5 hr. 04 min.
9. Birthplace Baltimore Maryland (Town, county, and State)
10. Usual Occupation None
11. Industry or business None
FATHER 12. Name John Thomas Williams
13. Birthplace Cofield N.C.
MOTHER 14. Maiden Name Della Bullock
15. Birthplace Hobgood N.C.
16 (a) Informant Della Williams
(b) Address 757 Redwood St
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 14 1946
18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 15 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH 10/11 1946, at 6:00 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1946, to 10/11 1946, and that I last saw her alive on 10/11 1946.
Immediate cause of death Prematurity - 32 weeks — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John W W Epperson M. D.
Address University Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

X

G11589 P.C.F.-59228 BALTIMORE CITY HEALTH DEPARTMENT G11589
CERTIFICATE OF DEATH 159 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Redwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME Baby Girl (A) Williams

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	Single

6 (b) Name of husband or wife
6 (c) If widow, date of death years

7. Birth date of deceased (mo., day, yr.) 10/11/46

8. AGE: Years	Months	Days	If less than one day
			8 hr. 10 min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name John William
13. Birthplace N.C.

MOTHER
14. Maiden Name Delah Bullock
15. Birthplace N.C.

16 (a) Informant Della Williams
(b) Address 708 Redwood St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 15 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1946 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1946 to 10/11 1946 and that I last saw h[illegible] alive on 10/11 1946

Immediate cause of death Prematurity 232 — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Clinic Hosp Date signed 10/11/46

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G11590 G11590

CERTIFICATE OF DEATH 15.10 ✓ 83a

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4013 Liberty Heights ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. Grossbach

(a) RESIDENCE NO. 4013 Liberty Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Sullivan

6 DATE OF BIRTH (month, day, and year) May 11, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	76	✓	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant O B Robinson

(Address) Forest Station, Md.

15 Filed OCT 15 1946 19 Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1:45 PM 1946

17

I HEREBY CERTIFY, That I attended deceased from Oct 12th, 1946, to Oct 14th, 1946,

that I last saw him alive on Oct 14th, 1946,

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hamorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J E Poulton, M. D.

10/14 1946 (Address) 8909 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burial Lorraine Park	10-17 1946

20 UNDERTAKER O B Robinson

ADDRESS Forestville, Md.

IMPORTANT. See INSTRUCTIONS ON BACK OF CERTIFICATE.

G21591 B.C.G.-58902 BALTIMORE CITY HEALTH DEPARTMENT G21591
CERTIFICATE OF DEATH X 160a
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 Fayette St.,
(c) Hospital or institution: Bon Secours Hospital,
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	32 hr. 15 min.

9. Birthplace Bon Secours Hospital (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Stanley LaVerne Gilbert
13. Birthplace Finksburg, Maryland

MOTHER
14. Maiden Name Effie Viola Blizzard
15. Birthplace Finksburg, Maryland

16 (a) Informant Mrs. Effie Viola Blizzard
(b) Address Finksburg, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 - 1946 (month) (day) (year)
(c) Cemetery or crematory BETHEL CEM.
Location BETHEL HEIGHTS, MD.
18 (a) Funeral director N.B. Bankard Sons
(b) Address Westminster, Md.
19 OCT 16 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/46 19 at 2:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946, to Oct 15 1946, and that I last saw him alive on Oct 15 1946.

Immediate cause of death	Duration
Pulmonary edema	12 hours
Due to Cerebral Hemorrhage	32 hours
Due to Anemia at birth	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Fowler M. D.
Address Bons Secours Hosp Date signed 10-15-46

VS 100

X

AB-104807 D BCH 56429 BALTIMORE CITY HEALTH DEPARTMENT 30F Registered No. G24598

CERTIFICATE OF DEATH

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 West Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janice Marie Browning

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 13- 1946

8. AGE: Years	Months	Days	If less than one day
		28	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alex John Browning
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Ray Blevins
15. Birthplace Ky.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-17-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 OCT 16 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11- 1946, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26- 1946 to 10-11- 1946 and that I last saw h er alive on 10-11- 1946

Immediate cause of death: Hepatitis — Duration 3 wks.
Due to
Due to Congenital Syphilis — 5 mos.
Other Conditions Herxheimer Reaction — 1 wk.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy Congenital Malformation of Both Kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lillian B. Griffin
Address Baltimore City Hosp. Date signed 10/14/46

VS 150

G44583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G44583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 E. Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Entwistle, Alfred

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie Whalley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1886

8. AGE: Years	Months	Days	If less than one day
60	6	26	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Seafarer

FATHER
12. Name Thomas Entwistle
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Records
(b) Address U.S.Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Fairmount Md.

18 (a) Funeral director Pulliam
(b) Address 1219 E Fort Ave

Filed by Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1946 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 12 1946 to Oct. 15 1946, and that I last saw him alive on Oct. 15 1946

Immediate cause of death (1) Coronary sclerosis with stenosis of right coronary artery.
Due to (2) Cerebral thrombosis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As Above

Duration
Unknown
2 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address U.S. Marine Hospital, Baltimore, Maryland Date signed 10/15/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

Registered No. G44594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 S London Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S London Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence C Nicholson

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11 1881

8. AGE: Years 65 | Months 3 | Days 3 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Herbert Miller
13. Birthplace: Md

MOTHER
14. Maiden Name: Elizabeth Schuck
15. Birthplace: Md

16 (a) Informant: Louis D Nicholson
(b) Address: 113 S London Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 17 1946 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md

18 (a) Funeral director: Wilford Co Inc
(b) Address: 1707 East St

19 (a) OCT 16 1946 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946, at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1946, to Oct 14 1946, and that I last saw h[illegible] alive on Oct 13 1946.

Immediate cause of death: Carcinoma of uterus metastasis to liver — Duration: 1 yr.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: J P Collins M. D.
Address 3317 Nederick Date signed 10-18-46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

~~24595~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered ~~24595~~

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dunbland & Rayner Aves.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 N Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BERTHA WILLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Burnard G
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18 1879

8. AGE: Years	Months	Days	If less than one day
66	11	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Adler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry Wills
(b) Address 1947 Federal St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilhoyte Co Inc
(b) Address 1219 N Pont St

19 (a) Date received by Registrar OCT 16 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/46 1946, at 5:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12, 1946, to Oct 15 1946, and that I last saw h[illegible] alive on Oct 15 1946.

Immediate cause of death	Duration
Myocardial Infarction	4 days
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Rubinkam
Address 3706 Rosedale Rd Date signed 10/15/46

VS 190

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G44536

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. Gates St. Bay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Forrester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Lillian (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1874

8. AGE: Years 72 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Decorator

11. Industry or business

FATHER
12. Name John K. Forrester,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amelia Joyce
15. Birthplace Baltimore, Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Taylor
(b) Address 1317 Eutaw St

19 OCT 16 1946 (Date received by registrar) Huntington Williamette, Md (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15- 1946, at 12.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9- 1946, to 10-15- 1946, and that I last saw h im alive on 10-15 1946.

Immediate cause of death Respiratory failure

Due to Bronchopneumonia

Due to

Other Conditions Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Dayle Waldron M. D.

Address B C H Date signed Oct 15/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 91a

Registered No. G44597

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 161 E. Randall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-31-99

8. AGE: Years 46 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business R R Express agcy.

FATHER
12. Name Thomas Rose
13. Birthplace Md

MOTHER
14. Maiden Name Katie Heline
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo L. Bayne Jr
(b) Address 1512 Hollins St

19 OCT 16 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946 at 4 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 14 1946 and that I last saw he alive on Oct 14 1946.

Immediate cause of death	Duration
Myocardial failure	
Due to subacute bacterial endocarditis	
Due to Bacteriodes	
Other Conditions Pulmonary infarction	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Arntzen
Address Johns Hopkins Hospital Date signed 14 Oct 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G44598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G44598

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010 Boyd St
(c) Hospital or institution: — — — 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County — —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 Boyd St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Robert C. Schroeder

3 (b) If veteran, name war —

3 (c) Social Security Account No. — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Bertha A. Schroeder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9-1860

8. AGE: Years	Months	Days	If less than one day
85	11	3	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Cabinet Maker
11. Industry or business Retired

FATHER
12. Name Carl Schroeder
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs Elizabeth Hewitt
(b) Address 2010 Boyd St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct 16 46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Geo L Berger Jr
(b) Address 1512 Hollins St

19 (a) OCT 16 1946 (Date rec'd by registrar) **(b)** Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1946 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1946 to Oct 12 1946 and that I last saw him alive on Oct 12 1946

Immediate cause of death
Cerebral Hemorrhage
Duration Oct. 8

Due to Arterio Sclerosis, Ruptured

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Maud C. Boyd M.D.

Address 1905 W. Pratt St Date signed 10-15-46

X

C44599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

C44599 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Lorman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eliza Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1886

8. AGE: Years	Months	Days	If less than one day
60	-	10	hr. min.

9. Birthplace Matthews Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Peter Thompson

13. Birthplace Matthews Co. Va.

MOTHER 14. Maiden Name Fannie Billups

15. Birthplace Matthews Co. Va.

16 (a) Informant James Monroe Robinson

(b) Address 1808 Lorman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Thos. George W. Hall

(b) Address 1699 Druid Hill Ave

19 (a) Date rec'd by local registrar OCT 16 1946 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/46 19 . at 9:20 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/10 19 46 to 10/12 19 46 and that I last saw h alive on 10/12/46

Immediate cause of death — Duration

Due to Rt. Lobar Pneumonia 2 days

Due to Renal Calculi Yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H Haddelcone

Address 453 Harlem Ave Date signed 10/15/46

C24600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59 B

Registered No. C24600

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 139 W. Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 W Hamburg St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife Sutton Spriggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1868

8. AGE: Years	Months	Days	If less than one day
77	9	19	hr. min.

9. Birthplace St. Michaels md (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Unknown.

MOTHER
14. Maiden Name Mary Lawrence
15. Birthplace St Michaels

16 (a) Informant Annie Allen
(b) Address 116 W Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto. Md.

18 (a) Funeral director George T. A. Gibson
(b) Address 1730 W. Baltimore St.

19 (a) (Date received by Registrar) OCT 18 1946 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Oct 13 1946, and that I last saw h[illegible] alive on Oct 19 46.

Immediate cause of death
Old age
Cardiac insufficiency
Due to
Due to
Other Conditions Arthritis

Duration
4-5 years

(Include pregnancy within 3 months of death)
Major findings
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 1431 W Franklin Date signed 10-16-46

95c

G44601
501781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓157E

G44601
Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Fairmount
(If outside city or town limits, write RURAL and give town)
(d) Street No. 639 Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mario Liparoi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-6-39.

8. AGE: Years 7. Months 5 Days 9 If less than one day hr. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Liparoi
13. Birthplace W Va.

MOTHER
14. Maiden Name Helen Marra
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17/46 (month) (day) (year)

(c) Cemetery or crematory
Location Fairmount W Va.

18 (a) Funeral director Chas O. Mitchell & Sons
(b) Address 1900 Eutaw Place.

19 (a) OCT 16 1946 (b) Signature Thos Williams M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1946, at 8.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1946 to Oct. 15 1946, and that I last saw him alive on Oct. 15 1946.

Immediate cause of death	Duration
Cerebral anoxia	12 hrs.
Due to Operation for	1 d.
Due to Pulmonary Stenosis	Life
Other Conditions Coeliac Anemia. (Include pregnancy within 3 months of death)	4 yrs.

Date of operation 10-13-46

Major findings of operation: Pulmonary Stenosis

of autopsy: " & Coeliac Anemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. B. Morrow M. D.
Address JHH Date signed 10-15-46

VS 150

G44602

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

Registered No. G44602

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N. Greene Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Greene Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Garbo

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-22-1352

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Angeline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1875

8. AGE: Years 71 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Produce

11. Industry or business

FATHER
12. Name Vincent Garbo
13. Birthplace Italy

MOTHER
14. Maiden Name Cascio
15. Birthplace Italy

16 (a) Informant Mary Tamburino
(b) Address 816 E Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Joseph Sanace Inc.
(b) Address 201 S Eutaw and Ave

19 (a) (Date received by registrar) (b) Registrar

OCT. 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 11 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1946 to Octob. 13 1946, and that I last saw him alive on Octob. 13 1946

Immediate cause of death	Duration
Due to Cancer of rectum	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation May 31, 1946

Major findings of operation: None
Cancer of rectum

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph A. Rosenblatt M. D.

Address 3018 O'Donnell St. Baltimore, 24, Md Date signed 10-15-46

G44603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G44603

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave
(c) Hospital or institution: Mrs Smith's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town 1309 Park Ave - Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. (1309 Park Ave) (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Douglas Hanson

3 (b) If veteran, name war — No

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary Gracon Hanson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 16 1876

8. AGE: Years 70 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Crier of Court

11. Industry or business Balto Co. Court

FATHER
12. Name Peter N. Hanson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Stofaker
15. Birthplace Maryland

16 (a) Informant Mrs L. Wetherby - sister
(b) Address 1309 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-46 (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Edward H. Mowbray Co.
(b) Address 108 W Mount Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 1946, at 4.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Oct 1946 to 14 Oct 1946, and that I last saw him alive on 14 Oct 1946

Immediate cause of death: Coronary occlusion — Duration

Due to Arterio-sclerosis

Due to Senility

Other Conditions Cerebral Arterio-sclerosis etc

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury None

23. Signature D. Conrad Arndt MD

Address 712 Park Ave Balto 1 Md Date signed 15 Oct 1946

VS OCT 16 1946 Huntington Williams, M.D.

G44604 BALTIMORE CITY HEALTH DEPARTMENT G44604

CERTIFICATE OF DEATH 52 B

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 N Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 948 N Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geo. C. Personette

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daisy Evans
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 1 1873

8. AGE: Years 73 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Floor

11. Industry or business

FATHER 12. Name Thos Personette
13. Birthplace Balto

MOTHER 14. Maiden Name Sarah E Holmes
15. Birthplace Balto

16 (a) Informant Daisy Personette
(b) Address 948 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18 (month) (day) (year)
(c) Cemetery or crematory Laudon Park
Location Catty

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Aliceanna St

19 (a) (Date rec'd by registrar) (b) Filed Huntington Williams, M.D.

VS OCT 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946, at 9 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Oct 14 1946 and that I last saw h alive on Oct 5 1946

Immediate cause of death Respiratory failure
Due to Carcinoma of Bladder
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Sborofsky M.D.
Address 601 N Broadway Date signed 10/15/46 M.D.
Sborofsky

G44605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1116

Registered No. G44605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Wilson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Bryant

3 (b) If veteran, name war W. W. II

3 (c) Social Security Account No. 215-05-3550

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1904

8. AGE: Years 42 | Months | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charles Bryant
13. Birthplace N. C.

MOTHER 14. Maiden Name Rebecca Bryant
15. Birthplace N. C.

16 (a) Informant Leroy Bryant
(b) Address 524 W West st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 644 West Baltimore Street

19 (a) OCT 16 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 1946, at 8:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelley M.D. Medical Examiner.
Date signed 15 Oct 46

VS 191

G44606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G44606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Belmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSHUA BOND

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Catherine Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1878

8. AGE: Years	Months	Days	If less than one day
68	3	1	hr. min.

9. Birthplace Butler, Md.
(Town, county, and state)
10. Usual Occupation Retired Farmer
11. Industry or business

FATHER
12. Name John Bond
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Mary Louise Benson
15. Birthplace Md.

16 (a) Informant Mrs. Catherine Bond
(b) Address 3016 Belmont Ave.

17 (a) Burial (b) Date thereof 10/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Jessups, Balto. Co., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 16 1946

VS 000

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1946 at 6:14 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1943 to Oct 13 1946, and that I last saw h/ alive on Oct. 12 1946.

Immediate cause of death	Duration
R.F. Hemiplegia.	
Due to Hypertension.	
Due to Chr. Nephritis.	
Other Conditions.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 520 Medical Arts Bldg. Date signed 10/17/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Berry

G44607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G44607 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 N. Spring St
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9. 1880

8. AGE: Years 66 | Months 9. | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name William Henry
13. Birthplace Md

MOTHER 14. Maiden Name Mary Paul
15. Birthplace Md

16 (a) Informant Georgia Scott
(b) Address 1814 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 16 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Paynter Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 16 1946 (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 · 12 1946, at 1P · M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15 1946 to Oct 12 1946, and that I last saw h alive on Oct 12 1946

Immediate cause: Acute Myocarditis — Duration 15

Due to Chr. Nephritis — 7 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed 10 · 13 · 46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

Huntington Williams, M.D.

G44603
AB-105067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G44603
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Anna Bangert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1- 1898

8. AGE: Years 48 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Schaller (D
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Koch (D
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director Lilly & Zeiler, Inc.,
(b) Address 403 S. Wolfe St.

19 (a) 10-16-1946 (Date received by local registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14- 1946, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7-46 1946, to 10-14- 1946, and that I last saw her alive on 10-14 1946.

Immediate cause of death: Cardiac failure
Due to: Rheumatic cardiac vascular disease
Due to:
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Vadhon M. D.
Address B.C.H. Date signed Oct 15 1946

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C44609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C44609

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 326 S. Bouldin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) City Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 S Bouldin St
(If rural give location)
(e) Citizen of foreign country? 20 (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Kellner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	widow

6 (b) Name of husband or wife Anthony
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/11/1862

8. AGE: Years	Months	Days	If less than one day
84	3	13	hr. min.

9. Birthplace Balto - Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Paul Minnich
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant Laurena W. Kellner
(b) Address 326 S. Bouldin St

17 (a) Burial (b) Date thereof 10/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Tilly & Zeiler Inc
(b) Address 403 S. Wolfe St

19 (a) (b) Registrar
(Date rec'd by registrar)

OCT 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to Oct 14 1946, and that I last saw h.e. alive on Oct 14 1946

Immediate cause of death: Cerebral Hemorrhage 10/14 — 46
Arteriosclerosis (Senile)

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Sheehan M. D.
Address 3426 Bank St Date signed Oct 16

Huntington Williams, M.D.

G44610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44610 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 W
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Carnes

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife: Harry Carnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 31, 1860

8. AGE: Years	Months	Days	If less than one day
86	0	14	hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: Edward Lucas
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Sophia --
15. Birthplace: Balto. Md.

16 (a) Informant: Wilbert H. Carnes
(b) Address: 213 N. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Stewart Sons
(b) Address: 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1946 19 , at 1 32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1946 to Oct 14 1946, and that I last saw her alive on Oct 13 1946.

Immediate cause of death	Duration
Chronic myocarditis	1 year
Coronary Thrombosis -	Oct 14/46
Due to arterio - sclerosis	—
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Louis A. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed Oct 15/46

VS 150

G44611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44611

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie [redacted] Stamm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16-1886

8. AGE: Years 60 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Goos
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Crane
15. Birthplace Germany

16 (a) Informant Reed Stamm
(b) Address 4009 Taylor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Jos. J. Herrmann
(b) Address 3601 Hamilton Ave

19 OCT 16 1946 (Date received by registrar) Benjamin Wilmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1946, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1946, to Oct 14 1946, and that I last saw h[illegible] alive on Oct 14 1946.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Arteriosclerotic Hypertensive Cardio-Vascular Disease

Due to Cardiac Failure

Other Conditions Pulmonary Edema.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy See Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Heuchemann M.D.

Address Sinai Hospital Date signed 10/17/46

VS 150

G44612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G44612 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Cecilia Mullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1887

8. AGE: Years 59 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER 12. Name John J. Mullen
13. Birthplace Va

MOTHER 14. Maiden Name Catherine Shaw
15. Birthplace Va

16 (a) Informant Miss Mullen
(b) Address 932 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17. 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

OCT 16 1946 (b) Lexington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 October 1946 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 46 to October 19 46. and that I last saw her alive on 13 October 1946

	Duration
Immediate cause of death Cerebral Hemorrhage	10 min.
Due to Hypertensive cardio-vascular disease	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.

Address 501 Sheridan Ave. Date signed 17 Oct. 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G44613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1116

G44613 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1514 W Lanvale St

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1514 Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida D. Shields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rogers Hershield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1881

8. AGE: Years 65 | Months 2 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nicholas Matthews
13. Birthplace Frederick Md

MOTHER
14. Maiden Name Jennie Roles
15. Birthplace Frederick Md

16 (a) Informant Rogers Hershield
(b) Address 1514 W. Lanvale St

17 (a) (Burial, cremation, or removal) **(b) Date thereof** 16-17-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore Md

18 (a) Funeral director Archibald A. Haddix
(b) Address 1401 Mc Culloh St.

19 (a) OCT 16 1946 (Date rec'd by registrar) Huntington Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 1946, at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William H. Keffer M.D.
Medical Examiner.
Date signed 15 Oct 46

G44614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124 B G44614 Registered No.
FRAUNHOLZ

please write the causes of death clearly and legibly. Physicians: please state whether deaths from violence (external causes) were accidental, suicidal or homicidal. Information as to whether a case is reportable to the Coroner should be given. Please state whether a woman was pregnant at the time of death or had been pregnant within three months of death. Please state whether a death was due to a communicable disease. Please state whether a surgical operation was performed within four weeks of death. Please state whether an autopsy was performed. Please state whether tuberculosis existed and was a contributory cause. Please state when, where and how long deceased was attended. Please give full name and address of informant. Please write plainly. Please answer all questions. Please give the information requested in as complete detail as possible. Please do not abbreviate. Please do not use ditto marks. Please do not use initials. Please do not use figures. Please do not use symbols. Please do not use abbreviations

G44615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registration No. G44615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Arunah Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATILDA M. BORCHERS

3 (b) If veteran, name war ********
3 (c) Social Security Account No. *******

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Herman H. Borchers
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) March 14, 1879

8. AGE: Years	Months	Days	If less than one day
67	7	--	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name John Uhl
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Herman Borchers (son
(b) Address 2922 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 17 Oct. 46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director C. B. Shipley & Sons
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Clayton Williams, Registrar

OCT 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 46 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 47 to Oct 14 19 46 and that I last saw h. alive on 10/12 19 46.

Immediate cause of death: Coronary Occlusion — Duration: Sudden
Due to: Angina Pectoris — 10 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elsie W. Johnson
Address 3432 Tudor Ave Date signed 10/16/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G44616 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore - 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 German Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Schroeder — "George A. Schroeder"

3 (b) If veteran, name War —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Schroeder
6 (c) If alive, give age 72 years

7. Birth date of decessed (mo., day, yr.) May 26-1879

8. AGE: Years	Months	Days	If less than one day
67	4	18	hr. min.

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Schroeder
13. Birthplace Europe GERMANY

MOTHER
14. Maiden Name Maria Mandeda
15. Birthplace Europe Germany

16 (a) Informant Mrs. Helen Schroeder
(b) Address 20 German Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 17 Oct 46 (month) (day) (year)
(c) Cemetery or crematory Loreauing Park
Location Woodlawn, Md

18 (a) Funeral director C. D. Philpott & Sons
(b) Address 1100 Eutaw Place

19 (a) (Date rec'd by reg'r) OCT 19 1946 (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5, 1946, to Oct 13 1946, and that I last saw him alive on 10/13/1946.

Immediate cause of death Cerebral Embolism — Duration

Due to Auricular Fibrillation — 13 days

Due to Coronary Occlusion — 13 days

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S. Kellett M.D. M. D.
Address Dover Del. Date signed 10/15/46

94a

G44617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) ~~Ward~~ or Address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 342 E. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Spencer N. Chalk.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female 5. Color or race Col 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) February 23, 1886

8. AGE: Years 60 Months 7 Days 21 If less than one day hr. min.

9. Birthplace Hobson Va. (Town, county, and State)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Alfred Wilson

13. Birthplace Va

MOTHER 14. Maiden Name Harriett Carter

15. Birthplace Va

16 (a) Informant Marie Chalk Floyd

(b) Address 342 E. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Robert L. Young

(b) Address 1216 E. Caroline St.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1946 at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1926 to 9-24 1946 and that I last saw him alive on 9-24 1946

Immediate cause of death: arterio sclerosis Duration 15 years
Chr. myocarditis 2 years
Due to general arterio sclerosis 2 years
Coronary sclerosis 6 months

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. A. McCutcheon M. D.

Address 2270 Eutaw Pl. Date signed 10/15/46

Huntington Williams M.D.

VS 150

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G94618 BC# D 59172 G94618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4710 Greenhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Baby Karavedas.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Evelyn
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days: 1 | If less than one day: 30 hr. 30 min.
9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name: Konstantine
13. Birthplace: Balto. md.
MOTHER 14. Maiden Name: Caldwell
15. Birthplace: Balto Md
16 (a) Informant: Konst Karavedas.
(b) Address: 4710 greenhill ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-46 (month) (day) (year)
(c) Cemetery: Greek Cem. Location: Windsor Mill Rd.
18 (a) Funeral director: Lambros Funeral
(b) Address: 438-440 E. North ave
19 (a) 1946 (Date rec'd by registrar) Washington Nicholas (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15, 1946, at 8:40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to Oct 15 1946 and that I last saw h[illegible] alive on Oct 15 1946.

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Manuel Eguia M.D.
Address: Maryland Gen. Hosp. Date signed 10/23/46

VS 150

X

GA4619 BC# B58305 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. B-44619

Please write the causes of death clearly and legibly. Physicians: please fill out all items. Entries on this certificate are especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Canneton Cove (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby f Thelma Lewis (Byrant H. Lewis)

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-46

8. AGE: Years	Months	Days	If less than one day
	1	30	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Roosevelt H. Lewis
13. Birthplace S.C.

MOTHER
14. Maiden Name Thelma Carter
15. Birthplace Balto. Md.

16 (a) Informant Thelma Lewis
(b) Address 211 N. Canneton Cove.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Registrar Washington Williams

OCT 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-1946, at 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1946, to 10-15-1946, and that I last saw him alive on 10-15-1946.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lewis Jr. Jones

Address 1104 Druid Hill Ave Date signed 10/16/46

2145 W. Pratt St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G44620 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 West Pratt Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2215 W. Pratt St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Twd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Getz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jacob Getz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1859

8. AGE: Years	Months	Days	If less than one day
87	3	28	hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Barbara Fischer
(b) Address 2215 West Pratt Street

17 (a) Burial (b) Date thereof Oct. 17, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Hollins & Gilmor Sts.

OCT 16 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1946, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1- 1946 to 10/14 1946 and that I last saw h. alive on 10/12 1946.

Immediate cause of death

	Duration
(a) Myocarditis	9 yrs
Due to Hypertension	"
Due to Arterial Sclerosis	"
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar A. Culbreth M. D.
Address 2145 W. Pratt St Date signed 10/15/46

X

G44621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G44621 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 S. Eaton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Petro Dominski or Dominsky

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-24-9103

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) not know

8. AGE: Years About 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

BOTHER'S FATHER'S

12. Name not know

13. Birthplace Russian

14. Maiden Name not know

15. Birthplace Russian

16 (a) Informant Mr. Jacob J. Wolzesko

(b) Address 8042 Phila. Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17-46 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian

Location Stony Run Md. B.C. County

18 (a) Funeral director John A. Grebliunckas Jr.

(b) Address 423 S. Paca St

19 (a) (Signature and title of official) Huntington Williams M.D.

(Date received by Registrar)

OCT 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/46 19 3:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 19 46 to 10/15 19 46 and that I last saw h[illegible] alive on 10/15 19 46.

Immediate cause of death: Coccix Fracture — Duration

Due to: Carcinoma of Pancreas

Due to: with multiple metastasis involving liver, Lung & Mediastinal Glands

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells

Address St Jos Hosp Date signed 10/15/46

X

G24622 — BALTIMORE CITY HEALTH DEPARTMENT — G24622

CERTIFICATE OF DEATH 54a

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Grant
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joan P. Mitchell
3 (b) If veteran, name war —
3 (c) Social Security Account No. None
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 14 1940
8. AGE: Years 6 Months 6 Days 1 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation School Girl
11. Industry or business
FATHER 12. Name John Mitchell
13. Birthplace Baltimore Md
MOTHER 14. Maiden Name Alfonsina A. Plunges
15. Birthplace Baltimore Md
16 (a) Informant Alfonsina A. Mitchell
(b) Address 1530 Hollins St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md
18 (a) Funeral director Taft C & B.M. Walter
(b) Address Pratt & Stricker Sts
19 (a) (Date received by registrar) (b) Registrar
OCT 19 1946
Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1946, at 11:22 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1946 to Oct. 15 1946 and that I last saw h alive on Oct. 15 1946
Immediate cause of death Respiratory failure — Duration
Due to Circulatory collapse — Duration
Due to Retinis bleeding; Anemia — Duration
Other Conditions Complete contusion of scrotum with testicular hemorrhage due to pressure — Duration 1 week
(Include pregnancy within 3 months of death)
Date of operation Oct. 5, 1946
Major findings of operation: Tumor of left cerebral hemisphere
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Robert L. McCarthy M. D.
Address University Hospital Date signed 10-15-46
Howard J. Mason, M.D.

G14623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G44623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 N. Charles Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VICTOR HUGO SPRAGUE (SPRAGUE)

3 (b) If veteran, name war WWI
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ann Sprague
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 8, 1888
8. AGE: Years 58 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Washington D C
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Printing Shop

FATHER
12. Name Victor Sprague
13. Birthplace Washington D C

MOTHER
14. Maiden Name Florence Statt
15. Birthplace Illinois

16 (a) Informant Mrs Wm Sprague
(b) Address 2110 N Charles St
17 (a) Cremation (b) Date thereof 10/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Alleghany
Location Frostburg Md
18 (a) Funeral director Kilbourn & Sons
(b) Address 2106 Pennsylvania Ave
19 (a) OCT 16 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946, at 5:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 10/14/46

VS 181

G14624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G14624 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St - Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Francis St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Frankel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Hyman Frankel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years: 48 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant: Hyman Frankel
(b) Address: 2500 Francis St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-46 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location:

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1129 E. Baltimore St

19 (a) OCT 16 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1946, at 8 29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4/46 to 10/15/46 and that I last saw h[illegible] alive on 10/15/46

Immediate cause of death: Cardiac Failure — Duration:
Due to:
Due to: Rheumatic Heart Dis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Samuel D Daly M.D.
Address: Sinai Hospital Date signed 10/17/46

VS 150

Write the causes of death clearly and legibly. Physicians: please write correct age if especially important.

G44625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1497

G44625 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4312 Parkmont Ave
(c) Hospital or institution:
Parkmont Nursing Home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELEANOR MOORES

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1859

8. AGE: Years	Months	Days	If less than one day
87	7	17	hr. min.

9. Birthplace Norfolk, Co. Virginia (Town, county, and state)
10. Usual Occupation School Teacher(Retired)
11. Industry or business Education

FATHER
12. Name Samuel Lee Moores
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Frances L. Old
15. Birthplace Norfolk Co., Virginia

16 (a) Informant Geo. O. Moores
(b) Address 3210 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 17, Oct. 46 (month) (day) (year)
(c) Cemetery or crematory All Saints P.E.
Location Reisterstown, Md.

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 W. North Ave.

19 (a) Date received 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1946, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1946, to Oct. 14 1946, and that I last saw h[illegible] alive on Oct. 12 1946

Immediate cause of death: Carcinoma of vulva — Duration 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Owen Moores M. D.
Address 3105 Belair Rd Date signed 10-14-46

VS 150

G44626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

G44626 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3521 Lucille Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Lucille Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Shea

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Phillip P. Shea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11-1870

8. AGE: Years	Months	Days	If less than one day
76	9	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business Housewife

FATHER
12. Name Adam Kraft
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Phillip P. Shea
(b) Address 3521 Lucille Ave

17 (a) Burial (b) Date thereof 10- 18
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md.

18 (a) Funeral director Hyman & Fleming
(b) Address 1426 Light St.

OCT 16 1946 (b) Huntington Wills Baltimore Md
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1946, at 11A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 29th 1946 to October 15 1946 and that I last saw h. liv alive on October 15 1946.

Immediate cause of death

	Duration
Angina Pectoris	Sep 29/46
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Burbat M. D.
Address 502 Park Heights Ave Date signed 10/15/46

VS 190

Dr. Mc Carthy
37 W. P[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G246837

Registered No. 46E

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Erdman Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Erdman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Crasanca Sadie Storath

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Fred Storath
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1884

8. AGE: Years	Months	Days	If less than one day
62	2	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Michael Dunkes
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa Geiseregan
15. Birthplace Md.

16 (a) Informant Mr. Fred Storath
(b) Address 2908 Erdman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 18 1946 Huntington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14th, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1946 to Oct 14 1946
and that I last saw h[illegible] alive on Oct 12 1946

Immediate cause of death Cancer of the colon with metastases in liver

Duration 4 Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry D. McCarty
Address 37 W. Preston St Date signed 10/15/46 M.D.

G14628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G14628 Registered No. 1706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glen Arm
(If outside city or town limits, write RURAL and give town)
(d) Street No. Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~THOMAS~~ Theodore Evans WERTHER

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. 220-14-0963

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1923

8. AGE: Years 21 | Months 4 3 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Carroll Werther
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Bessie M. Evans
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. C. Werther
(b) Address Harford Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10 19 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Loyola Funeral Home
(b) Address 7401 Belair Rd.

19 (a) OCT 16 1946 (Date received by Registrar) **(b)** Huntington Williamson MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1946, at 2.17 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fracture of Skull
Intracranial Hemorrhage

Due to

Other Conditions Burns, lacerations, abrasions and contusions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 27/8

(a) Date of injury 10-16-46 at 12.30 A.M.
(b) Where did injury occur? Loch Raven Blvd. & Belvedere Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public **While at work?** No
(d) Means of injury Driver of auto struck by another auto

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-16-46

(over)

G44629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G44629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 Homestead St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Homestead St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E Evans

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4 Sex	5 Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1871

8. AGE: Years	Months	Days	If less than one day
76	6	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Bait Transport

FATHER
12. Name Andrew J Evans
13. Birthplace Md

MOTHER
14. Maiden Name Sarah
15. Birthplace Md

16 (a) Informant Edith Evans
(b) Address 939 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 St Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Hilligues M.D. Registrar

OCT 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1946 to Oct 16 1946 and that I last saw h[illegible] alive on Oct 16 1946

Immediate cause of death	Duration
Thrombosis	
after dilated Heart	
Due to Cerebral Hemorrhage	2 hrs
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott Tucker M. D.
Address 928 E. North Ave Date signed 10/16/46

G44630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 209
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert.
(c) City or town Prince Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm Grahame
3 (b) If veteran, name war W
3 (c) Social Security Account No. none
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 24 1864
8. AGE: Years 82 Months 3 Days 24 If less than one day hr. min.
9. Birthplace Calvert Co. Md. (Town, county, and state)
10. Usual Occupation Retired farmer
11. Industry or business
FATHER 12. Name Thomas J. Grahame
13. Birthplace Calvert Co. Md.
MOTHER 14. Maiden Name Mary E. Billingsley
15. Birthplace Calvert Co. Md.
16 (a) Informant same as above.
(b) Address
17 (a) Burial (b) Date thereof 10/18/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory All Saints Memorial Location Calvert Co. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St
19 (a) (Signature of registrar) (b) Oct 1946 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1946, at 12 05 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3/47 1946 to 10/16 1946 and that I last saw h. alive on 10/16 1946.

Immediate cause of death	Duration
cerebral accident embolism	
Due to arteriosclerosis X	
Due to ca of prostate.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/5/46 — 4/23/46
Major findings of operation: ca prostate
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. D'Antonio M.D.
Address Church Home & Hosp. Date signed 10/16/46

VS 180

Correct Age is especially important. Physicians: please write the causes of death clearly and legibly.

G44631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 467

Registered No. G44631

Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Millville, N.J.
(If outside city or town limits, write RURAL and give town)
(d) Street No. ---
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clark, Joshua Hutchion

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Wid.

6 (b) Name of husband or wife --
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) April 6, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	10	hr. min.

9. Birthplace Bridgeton, New Jersey (Town, county, and state)
10. Usual Occupation Master
11. Industry or business Seafarer

FATHER
12. Name Edward Clark
13. Birthplace New Jersey

MOTHER
14. Maiden Name Sarah Jane Seeds
15. Birthplace New Jersey

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Port Norris
Location New Jersey

18 (a) Funeral director Wm. Cook Sons.
(b) Address 1217 E. Pratt St.

19 (a) OCT 17 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1946 at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1946 to Oct. 16 1946 and that I last saw him alive on Oct. 16 1946.

	Duration
Immediate cause of death (1) Peritonitis, acute, localized following resection of adenocarcinoma of	
Due to rectum.	Less than 21 days.
Due to (2) Thrombophlebitis left lower extremity.	Less than 21 days.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy As Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon, P.
Address Clinical Director Date signed 10/16/46

VS 180

G44632 B C# G3346 **BALTIMORE CITY HEALTH DEPARTMENT** G44632

CERTIFICATE OF DEATH ✓ 1147

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hosp - 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 12 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 551 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Gray

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 mo. 9/22/45

8. AGE: Years	Months	Days	If less than one day
1	12°	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Michael Gray
13. Birthplace Md.

MOTHER
14. Maiden Name Lucille Queen
15. Birthplace Md.

16 (a) Informant Lucille Stinney (Mother)
(b) Address 551 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery ~~cremation~~ Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) Huntington Williams, Registrar
(Date received by registrar)
OCT 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1946, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1946 to 10-16 1946, and that I last saw h~~im~~ alive on 10-16 1946.

Immediate cause of death Septicaemia — Duration

Due to Lung abscess
Post Traumatic abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. K. Briggs, M.D.
M. D.
Address Univ. Hosp. Date signed 10-16-46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G44633 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3220 Westwood Ave.
(c) Hospital or institution:
15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3220 Westwood Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE E. CHENOWETH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Herbert W. Chenoweth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1886

8. AGE: Years	Months	Days	If less than one day
59	9	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Frederick Kratz
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Herbert W. Chenoweth
(b) Address 3220 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form OCT 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1946, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1946 to Oct 15 1946 and that I last saw h[illegible] alive on Oct 1 1946

Immediate cause of death: Carcinoma breast
Metastasis — Duration: 6 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grant M. Rahn, M.D.
Address 1735 Pop 4 4 Date signed 10/16/46

X

G44634
ED-97036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

Reg. G44634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo- 15days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Harview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula C. Bachtell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Francis S. Bachtell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31- 1879

8. AGE: Years 67 Months 8 Days 16 If less than one day hr. min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Simpson
13. Birthplace Scotland

MOTHER
14. Maiden Name Eliza Mackelvain
15. Birthplace Balto Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar
(Date rec'd by registrar)

OCT 17 1946 Washington Hillsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 19 46 at 1.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1- 1945 to 10-16 1946, and that I last saw h ar alive on 10-16 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Heart Disease with	
Due to Arteriosclerosis Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac Hypertrophy & Dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr.
Address Balt. City Hosp. Date signed 10/16/46
M. D.

X

G44635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

G44635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 Paddington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Paddington Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: NANCY C. WHITTINGTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert J. R. Whittington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1905

8. AGE: Years	Months	Days	If less than one day
41	3	29	hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas J. Logan
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Anna Brunt
15. Birthplace England

16 (a) Informant Mr. Robert J. R. Whittington
(b) Address 308 Paddington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Govans Presby. Cem.
Location Balto., Md.

18 (a) Funeral Director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1946 to OCT 1946, and that I last saw h[illegible] alive on OCT 15 1946.

Immediate cause of death: CARCINOMA STOMACH — Duration 5 MOS.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph G. Hills M. D.
Address 18 E EAGER ST Date signed OCT 15, 1946

VS 150

4636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G-4636
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Division St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mo
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Division St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1860

8. AGE: Years	Months	Days	If less than one day
86	4	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Mathews
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Helen Mathews Sanko
(b) Address 2002 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18th 46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Westport Balto Md

18 (a) Funeral director George F. O. Gifford
(b) Address 1735 Druid Hill Ave

19 (a) OCT 17 1946 (Date rec'd by registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 46 to Oct 14 19 46 and that I last saw h[illegible] alive on Oct 1 19 46.

Immediate cause of death Chronic Cardio Vascular Disease — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr William Frey M.D.
Address 1928 Pa Ave Date signed Oct 14 46

VS 150

G44637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓128

G44637. Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hosp 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Wm Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1847

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George W. Brown
13. Birthplace Md

MOTHER
14. Maiden Name Francis Hooks
15. Birthplace Md

16. (a) Informant Lillian Aleton
(b) Address 1512 W Franklin st

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Westport Balto Md

18. (a) Funeral director George T. A. Gibson
(b) Address 1735 Druid Hill Ave

19. (Date received by Registrar) Oct 17 1946 at Huntingtown Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1946, at 8:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute hemorrhagic pancreatitis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/16/46

VS 161

G44638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

G44638 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 E.Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 E.Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver L.Frank

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Edna F.McClelland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 18,1896

8. AGE: Years	Months	Days	If less than one day
50	6	27	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Fulton Grand Laundry

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Edna F.Frank
(b) Address 1723 E.Lanvale St.

17 (a) Burial (b) Date thereof 10/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway

19 (a) OCT 17 1946 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1946; at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to 19 ; and that I last saw h.[illegible] alive on Oct 14 1946

Immediate cause of death: Coronary occlusion — Duration 6 hours
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Huntington Williams, M.D.
Address 2602 Harford Rd. Date signed Oct. 16 1946

Huntington Williams, M.D.

G44639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G44639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY HINES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	M

6 (b) Name of husband or wife Albert Hines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day hr. min.
38			

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ephriam Nutter
13. Birthplace Md.

MOTHER
14. Maiden Name Emma King
15. Birthplace Md.

16 (a) Informant Mrs. Albert Hines
(b) Address 524 N. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Memorial Park
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Frances M. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) OCT 17 1946 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1946, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1946 to Oct. 14 1946 and that I last saw her alive on Oct. 14 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial Damage	
Due to Rheumatic Ht. dis. w. aortic & mitral damage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Allan M. D.
Address Mercy Hosp Date signed 10/14/46

G44640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 B

Registered No. G44640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3718 Gough St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3718 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cosen C. Turner

3 (b) If veteran, name war: World war I
3 (c) Social Security Account No. 212-01-5162
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Gertrude B.
6 (c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): Aug 25 1896

8. AGE: Years	Months	Days	If less than one day
50	1	20	hr. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual Occupation: Knitter Setter
11. Industry or business: Knitting Mill Co.

FATHER
12. Name: Frank C. Turner
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary G. Bowman
15. Birthplace: Md.

16 (a) Informant: Gertrude B. Turner
(b) Address: 3718 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 18 46 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave Rd

18 (a) Funeral director: Martin W. G. Doppelt
(b) Address: 37 S. Ann St.

19 (a) Filed: OCT 17 1946 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16-46 19 , to 10-14-1946. and that I last saw h alive on 1946.

Immediate cause of death	Duration
Regina Pestoris	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantini, M.D.
M. D.
Address 234 S. Conkling St Date signed 10-16-46

X

AB-9721 G44641

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G44641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11mo-6days
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

15-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 Piedmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Harvey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31-1865

8. AGE: Years	Months	Days	If less than one day
81	2 3	15 16	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Spencer Harvey (D
13. Birthplace ?

MOTHER
14. Maiden Name Jane ? (D
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bath Hall -
Location 5301 Frederick Ave

18 (a) Funeral director Odd Funeral Home Inc.
(b) Address 4644 York Road

19 (a) (b) Registrar
(Date received by registrar)

OCT 17 1946

VS 198

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1946, at 3.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10-45 1945 to 10-16 1946, and that I last saw h. alive on 10-16 1946.

Immediate cause of death
Bronchopneumonia
Due to
Due to
Other Conditions Jaundice
Antemortem
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 10/18/46

X

G44642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G44642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 Presbury St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 Presbury St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna F. Downs Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: John H. Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1882

8. AGE: Years 63 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace A.A.Co., Md.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name John G. Downs
13. Birthplace A.A.Co., Md.

MOTHER
14. Maiden Name Mary A. Poulton
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John H. Jones
(b) Address 3122 Presbury St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) OCT 17 1946 (Date of registry) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1946, at 9.00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on Oct. 1946.

Immediate cause of death Coronary Occlusion. Duration 1 day

Due to myocarditis 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Poulton

Address 3904 Gwynnbrook Blvd Date signed 10/17/46 M. D.

Howard J. Lemmon, M.D.

4643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 94a

Registered No. 044643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MERCY HOSP.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 MINUTES
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Kent
(c) City or town CHESTER TOWN MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 WASHINGTON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. WILLIAM H. MOYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife MARTHA MOYER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1895

8. AGE: Years	Months	Days	If less than one day
51	7	26	-- hr. -- min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Chiropractor
11. Industry or business

FATHER
12. Name Nathaniel Moyer
13. Birthplace Penna.

MOTHER
14. Maiden Name Sarah Yiengst
15. Birthplace Penna

16 (a) Informant Martha Moyer
(b) Address Chestertown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory Hill Side
Location Roslyn, Pennsylvania

18 (a) Funeral director J. Willis Wells
(b) Address Chestertown, Md.

OCT 17 1946 (Date rec'd) (year) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/ 1946, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16/ 1946 to 10/16/ 1946, and that I last saw h[illegible] alive on 10/16/ 1946

Immediate cause of death CORONARY THROMBOSIS (1) — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl R. Paul
Address Mercy Hospital Date signed M.D. 10/17/46

For Dr. Williams, by Howard J. Mendelsohn, M.D.

4644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No. G34644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1728 Pressstman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 Pressstman St (If rural give location)
(e) Citizen of foreign country? yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Ada B. Hackett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Fem.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife James Hackett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1893

8. AGE: Years 53 Months 1 Days 10 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Bush
13. Birthplace Md.

MOTHER
14. Maiden Name Hattie Bailey
15. Birthplace Md.

16 (a) Informant Elizabeth Johnson
(b) Address 1728 Pressstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressstman St

19 (a) 7 1946 Huntington Williams M.D.
(b) Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15- 1946 at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10- 1946 to 10-15- 1946 and that I last saw h alive on 10-14, 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days
Due to Hypertension — 3 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page, M.D.
Address 516 N. Monroe St. Date signed 10-17-46

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G44645 (Registered No.) G44645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St. Agnes Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) mos-7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Paul Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5/05/1880

8. AGE: Years 66 | Months 54 | Days 11/18 | If less than one day hr. min.

9. Birthplace Germany (town, county and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name deceased
13. Birthplace

MOTHER
14. Maiden Name deceased
15. Birthplace

16 (a) Informant Mrs Ruth R. Braun
(b) Address 318 S. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Fredevick Ave

18 (a) Funeral director Harry A Wyatt
(b) Address 4101 Edmondson Ave

19 (a) (Date received by registrar) (b) (Registrar)

OCT 17 1946

Huntington Publishing Co., Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1946, at 5:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1946, to 10/16 1946 and that I last saw him alive on 10/16 1946.

Immediate cause of death: respiratory failure — Duration:

Due to ventricular fibrillation

Due to

Other Conditions Left intertrochanteric fracture of femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide acc. 20/8
(b) Date of occurrence 9-29-46 at P. M.
(c) Where did injury occur? Frederick ave & Aug (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Stumbled & fell on curb.

23. Signature [illegible]

Address St Agnes Hosp. Date signed 10/17/46

M. D.

Howard J. Sheeran, M.D.

G44646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G44646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin McCall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1913

8. AGE: Years	Months	Days	If less than one day
33	-	12	hr. min.

9. Birthplace Montgomery, Alabama
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Richard McCall
13. Birthplace Lowndesboro, Ala.

MOTHER
14. Maiden Name Annie Jackson
15. Birthplace Lowndesboro, Ala.

16 (a) Informant Richard McCall Sr.
(b) Address 1216 N. Eutaw St - Balto. Md.

17 (a) Burial (b) Date thereof Oct. 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Remount Cem.
Location Montgomery, Alabama

18 (a) Funeral director Fred Gus N. Hyllan
(b) Address 1681 Druid Hill Ave.

19 (a) OCT 17 1946 (b) Registered by registrar Huntington Williams M.D.
(Date received by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1946, at 3.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxia due to
Illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/15/46 about 1.00 P.M.
(b) Where did injury occur? 1618 Division St
(c) Did injury occur at home, on farm, industrial place, in public place? at Home While at work? no
(d) Means of injury Gas inhalation Coal Illuminating

23. Signature D. J. Gelbrinske M.D.
Medical Examiner.
Date signed 10/16/46

G44647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G44647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: Dr. Mc. Kenna's Memorial Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Belnord Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Oscar Fischer

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 217 - 14- 9177A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1869

8. AGE: Years	Months	Days	If less than one day
77	5	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name Gustav Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant William F. Hilgartner
(b) Address 3603 Yolando Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) Huntington Williams, M.D.

OCT 17 1946

VS 150

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH October 15 1946 at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1946 to Oct 15 1946 and that I last saw h. alive on Oct 15 1946.

Immediate cause of death: Cardiac Dilatation — Duration 3 Days

Due to Myocardial Insufficiency and Chronic Interstitial Nephritis — 2 yrs / 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg
Address 2005 E North Ave Date signed 10/16/46

X

14648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G14648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marion Edith Hans Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Wm. S. Levy

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 2 1876

8. AGE: Years	Months	Days	If less than one day
70 71	3	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Evan T. Hans
13. Birthplace Balto.

MOTHER
14. Maiden Name Marion E. Scott
15. Birthplace Balto.

16 (a) Informant Wm. S. Levy
(b) Address 2123 Linden ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1924 Eutaw Place

19 OCT 17 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Oct 1946 at 10:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Hoffacker M.D. Medical Examiner
Date signed 16 Oct 46

VS 151

G44649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

935

G44649 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 E 22½ St
(c) Hospital or institution:
12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 E 22½ St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
88			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Self employed
11. Industry or business

FATHER
12. Name Raney
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Albert Drewer
(b) Address 1413 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne Arundel Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) OCT 17 1946 (Date received by Registrar) (b) Huntington Hillsboro Md.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/46 19 , at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
(a) Bronchopneumonia, Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Evans M.D.
Medical Examiner.
Date signed 10/17/46

X

G44650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G44650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN STS.
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3/4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs 15

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 ALLENDALE RD
(If rural give location)
Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME PAULINE MARVEL HARGER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife GEORGE HARGER
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) FEB. 24, 1901

8. AGE: Years	Months	Days	If less than one day
45	7	22	hr. min.

9. Birthplace MUNCIE INDIANA
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name WILLIAM MASON
13. Birthplace MUNCIE INDIANA

MOTHER
14. Maiden Name ETTA BROWN
15. Birthplace MUNCIE INDIANA

16 (a) Informant PAULINE M. HARGER
(b) Address 2312 ALLENDALE RD.

17 (a) Removal (b) Date thereof 10/18/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Muncie, Ind.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 17 1946 Huntington Williams, Registrar
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 OCT. 1946, at 11:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 25 July 1946, to 16 Oct 1946, and that I last saw h.e.r. alive on 16 OCT 1946.

Immediate cause of death	Duration
CARDIORESPIRATORY FAILURE	
Due to BRONCHOPNEUMONIA	2 DAYS
Due to CARCINOMA OF OVARY WITH METASTASIS TO SPINE	14 YR.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Tepper Jr. M. D.
Address Women's Hospital Date signed 16 Oct '46

G44651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G44651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 Wheeler Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Wheeler Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ##

3 (a) FULL NAME Norman A. Dixon

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-03-7231

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Vallée Dixon

6 (c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): May 27, 1878

8. AGE: Years 68 | Months 4 | Days 20 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Buyer (Retired)

11. Industry or business: Calvert Drug Co.

FATHER
12. Name: James W. Dixon
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Bettie ? (Dixon)
15. Birthplace: Virginia

16 (a) Informant: Wife, Vallée Dixon
(b) Address: 2035 Wheeler Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19, 46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: Geo. W. Little
(b) Address: 2700 Edmondson Ave.

19 (a) (Date received by local registrar) (b) Registrar

OCT 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1946, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19__ to 10-17 1946 and that I last saw h alive on 10-16 1946

Immediate cause of death: Carcinoma Colon — Duration: 1 year

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 9-15-46

Major findings of operation: Inoperable Carcinoma

of autopsy: Transverse Colon

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: C. W. Peake M. D.

Address 1123 N. Paca Date signed 10-17-46

X

G44652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G44652 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 S. Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 S. Hanover (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. Bentz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. J. Bentz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 26 - 1889

8. AGE: Years 57 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Emanuel C. Becker
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Bowers
15. Birthplace: Baltimore

16 (a) Informant: Edward Becker
(b) Address: 1210 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 19-46 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Edmondson Ave.

18 (a) Funeral director: Elizabeth Hark Fns.
(b) Address: 115 E. West St.

19 (a) [illegible] Huntington Williams, M.D.
OCT 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12/1946 to 10/16/46 and that I last saw her alive on 10/15/1946.

Immediate cause of death: Cerebral hemorrhage — Duration: 5 days

Due to:

Due to:

Other Conditions: General and cerebral arterio sclerosis. — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harry Weisel M. D.
Address: 1226 Hanover St. Date signed: 10/17/46

1946.

VS 150

G44653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G44653 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 E Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A King

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Stephen King
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 8- 1859
8. AGE: Years 86 | Months 11 | Days 7 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Peter McKelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Gibbons
15. Birthplace Ireland

16 (a) Informant Mr Stephen R King
(b) Address 1732 Fourth Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Rd.
18 (a) Funeral director Elmer H. Corbin & Son
(b) Address 924 E. Eager St
19 (a) (Signature of local registrar)

OCT 17 1946

Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1946, at 12 50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Oct 15 1946, and that I last saw her alive on Oct 1st 1946.

Immediate cause of death	Duration
Mitral Regurgitation Thrombosis	15 days
Due to arterio sclerosis Hypertension	15 d
Due to Chr. Interstitial Nephritis	15 d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J A Stevens M. D.
Address 2818 Harford Rd Date signed 10 16 46

X

Dr. Cor. G44654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G44654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Pineridge Nursing Hone 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Shirey Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Seiland

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Ola J. Seiland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6th 1860

8. AGE: Years	Months	Days	If less than one day
86	3 4	7	hr. min.

9. Birthplace Norway
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Dora E. Seiland
(b) Address 2916 Shirey Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)

OCT 17 1946

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/46 19 at 10 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to Oct 15 1946, and that I last saw h[illegible] alive on Oct 15 1946.

Immediate cause of death Coronary occlusion — Duration 1 Day
Due to —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. A. Grady M.D.
Address 5106 Harford Rd Date signed 10-17-46

G44655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4
(c) Hospital or institution: Balto City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. PRATT + LONGDOCK. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Youse

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1867

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation SEA FOOD BUSINESS

11. Industry or business

FATHER
12. Name WILLIAM H. YOUSE
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARGARET LOCKINGLAND
15. Birthplace MARYLAND.

16 (a) Informant MARGARET L. CHELTON
(b) Address RIVERIA BEACH.

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof 10 (month) 19 (day) 46 (year)
(c) Cemetery or crematory WOODLAWN
Location GWYNN OAK. AVE.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) OCT 17 1946 (Date received by registrar) (b) Hunting for Williams

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16-1946, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Thurston M.D. (Medical Examiner.)
Date signed 10-16-46

G44656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G44656

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reistertown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 14 d
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo. 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County — ? —
(c) City or town Johnson City N.Y.
(If outside city or town limits, write RURAL and give town)
(d) Street No. — ? —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Sister Ariana Fitzpatrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/15/1886

8. AGE: Years	Months	Days	If less than one day
60	3	1	hr. min.

9. Birthplace Fitchburg Mass
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

MOTHER / FATHER

12. Name Michael M. Fitzpatrick

13. Birthplace Westboro Mass

14. Maiden Name Mary Agnes Fay

15. Birthplace Boston, Mass

16 (a) Informant The Seton Institute

(b) Address 6420 Reistertown Rd.

17 (a) Burial (b) Date thereof 10-18-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Seton Institute Cemetery

Location Seton Institute

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. Woodell Asst.) 100 W. North Avenue

19 (a) OCT 17 1946 (Date rec'd by local registrar) (b) Registered by Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1946, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1946, to Oct 16 1946, and that I last saw h Sx alive on Oct. 16 1946.

Immediate cause of death Left cerebral thrombosis duration 3 mo. — Duration

Due to Vegetative Endocarditis

Due to

Other Conditions Psychosis with cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Damian Lloyd M. D.

Address 33 W. Madison St. Date signed

X

G44657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44657
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 E. University Parkway
(c) Hospital or institution:
at home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 E. University Parkway (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3. (a) FULL NAME ELIZABETH MARGARET ERMOLD SLOATFIELD

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: George H. Sloatfield
6 (c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): April 30, 1890
8. AGE: Years: 56 Months: 5 Days: 16 If less than one day: hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: NONE
11. Industry or business: NONE

FATHER
12. Name: Edward Hermann
13. Birthplace: Alsace Lorraine

MOTHER
14. Maiden Name: Elizabeth Kratee
15. Birthplace: (Probably) Balto. Md.

16 (a) Informant: Mr. John G. Ermold (Son)
(b) Address: 225 E. University Parkway, City

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10-18-46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore City

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 105 W. North Ave., City

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1946 at about 1 PM

21. I certify that death occurred on the date stated above, at the hour stated above, and that I last saw deceased on Oct 15 1946 and that I last saw deceased alive on Oct 15 1946

Immediate cause of death

	Duration
Coronary occlusion	
Due to Arteriosclerosis	4 yrs
Due to Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Keeney, M.D.
Address 1 E. Lafayette Ave. 21202

VS 100

X

46

G44658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

Reg. G44658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 N. Calvert St.
(c) Hospital or institution:
at home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 N. Calvert St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME (MISS) JULIA JOHNSTON

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: NONE
6 (c) If alive, give age: XXX years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1868

8. AGE: Years	Months	Days	If less than one day
78	9	15	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Robert Johnston
13. Birthplace Virginia

MOTHER
14. Maiden Name Laura Criss
15. Birthplace West Virginia

16 (a) Informant Mrs. Margaret J. Rose (sister)
(b) Address 3129 N. Calvert St., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 N. North Ave., City

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946 to Oct 16 1946 and that I last saw h[illegible] alive on Oct 16 1946.

Immediate cause of death: Senility — Duration: Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. Chesbrough M.D.

Address 2923 St Paul St Date signed 10/17/46

X

4659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G44659
Registered No.

TH. 70636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4yrs 9-mo. 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 5201 Denmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Davis -or- Jake Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13th 1881

8. AGE: Years	Months	Days	If less than one day
64	11	24	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Davis
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Louise Smith
15. Birthplace Penn.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 17 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 17 1946 (Date) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7th 1946 at 7.40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 18 1941 to Oct 7th 1946 and that I last saw him alive on Oct. 7th 1946

Immediate cause of death: Bronchopneumonia — Duration 5 days
Due to
Due to
Other Conditions: Hypertension Cardiarterial Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Patterson Jr. M. D.
Address Balt City Hosp Date signed Oct 7 1946

VS 150

G44660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-31907

107

G44660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8yrs- 6mos. 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 1/2 Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pete Mazinyouk or Pete Mazinyouin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Catherine (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ?- 1873

8. AGE: Years	Months	Days	If less than one day
73	4	?	hr. min.

9. Birthplace Yugoslavia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stev
13. Birthplace Yugoslavia

MOTHER
14. Maiden Name Sally
15. Birthplace Yugoslavia

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 17 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 17 1946 (b) Harold J. Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23-38 1938, to 10-12 1946, and that I last saw h. im alive on 10-12- 1946

Immediate cause of death: Bronchopneumonia, Bilateral — Duration: 3days

Due to

Due to

Other Conditions Enlarged prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Rehmann Jr. M. D.
Address Balt. City Hosp. Date signed 10/15/46

G44661

BC#

91 58168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1570

✓ G44661 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6. Monument St
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 15 (If outside city or town limits, write RURAL and give town) 20
(d) Street No. 3835 Labyrinth Road (If rural give location)
(e) Citizen of foreign country (Labyrinth Rd or No)
If yes, name country

3 (a) FULL NAME Baby Boy GREIF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Wht.	NB.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1/46

8. Age Years	Months	Days	If less than one day
NB.		2	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leonard Greif, JR
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Dora Wbily
15. Birthplace Nebraska

16 (a) Informant Leonard Greif
(b) Address 3835 Labyrinth Rd.

17 (a) (Burial, cremation, or removal) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 17 1946

18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 17 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1946, at 3 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1, 1946, to Oct 3 1946, and that I last saw him alive on Oct 3 1946.

Immediate cause of death: absence Duct. Int. — Duration
Due to: Meconium ileus
Due to: Int. kidney abs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alvin Seamon M. D.
Address Sinai Hosp. Date signed 10-7-46

X

44662 Bd. J-59170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

G44662 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John St & Lafayette Ave.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr 44min
(e) Length of stay in Baltimore (yrs., mos., or days) 2hr 44min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4319 Marble Hall Road (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bowers

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	(illegible) born

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14th 1946

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hr. 44 min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation (illegible)

11. Industry or business

FATHER
12. Name Edwin C. Bowers
13. Birthplace Church Hill Maryland

MOTHER
14. Maiden Name Jean Caldwell McDonald
15. Birthplace Worcester Massachusetts

16 (a) Informant Jean C. Bowers (Mother)
(b) Address 4319 Marble Hall Road

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 17 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 17 1946 (Date rec'd by registrar) (Signature of registrar) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15th 1946, at 2:44 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 14th 1946, to Oct 15th 1946, and that I last saw him alive on Oct 15th 1946.

Immediate cause of death	Duration
Atelectasis	2 hrs
Due to Peripheral vascular shock	
Due to Prematurity Labor	2 hrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Women's Hospital Date signed 10/16/46

VS 3

4663 BC# B 58910 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 G44663

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 Talbott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1946

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Irving Bernard
13. Birthplace Maryland

14. Maiden Name Alva Rainier
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 17 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 17 1946 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 19 46 at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 11 19 46 to Oct. 11 19 46 and that I last saw him alive on Oct. 11 19 46

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Date signed

VS 150

G44664 ✓ G44664

502734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1561

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 4-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Evans.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-26-20.

8. AGE: Years	Months	Days	If less than one day
26	5	20	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Murphy.
13. Birthplace N. C.

MOTHER 14. Maiden Name Rizzie May.
15. Birthplace N. C.

16 (a) Informant Reynolds
(b) Address JOHNS HOPKINS Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-46 (month) (day) (year)
(c) Cemetery or crematory Greenville N. C.
Location N. C.

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presbyterian St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1946 at 7.55 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946 to Oct. 16 1946 and that I last saw h. alive on Oct. 16 1946.

Immediate cause of death: Dermatomyositis, acute — Duration 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not permitted

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. J. Davis

Address Johns Hopkins Hospital Date signed 10/16/46 M. D.

VS 1.50 46

G44665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G44665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring & Belvedere Ave
(c) Hospital or institution: Lunsdale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Vanna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Samuel Fox
(b) Address 1531 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-46 (month) (day) (year)
(c) Cemetery or crematory Beth David Cemetery
Location New York N.Y.

18 (a) Funeral director Jacob Rewa Inc
(b) Address 1439 E. Balto St
Huntington Williams

19 (a) Date received by Registrar OCT 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1946, to 10-17 1946 and that I last saw h[illegible] alive on 10-17 1946

Immediate cause of death: Carcinoma of stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature H. Edmund Levin, M.D.

Address Levindale Date signed 10/17/46

VS 150

X

G14666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G44666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 St Paul St.
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 St Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Walburg

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Minnie Walburg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	28	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Farmer Retired
11. Industry or business

FATHER	12. Name Thurston Walburg
	13. Birthplace Germany
MOTHER	14. Maiden Name Margaret O'Reilly
	15. Birthplace Ireland

16 (a) Informant Richard Sawyer
(b) Address 2329 Kentucky Ave
17 (a) Final disposition Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Wilbur Cook Jr.
(b) Address 1314 St Paul St

OCT 18 1946 (b) Date received Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Oct 14 1946, and that I last saw him alive on Oct 1st 1946

Immediate cause of death: Myocardial insufficiency
Due to Generalized Arteriosclerosis

Duration
5 yrs
2 yrs

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas L. Wardley Jr. M.D.
Address 2010 Alameda Date signed 10/19/46

VS 150

G44667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G44667

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 Hilsmont Court
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Hilsmont Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Arthur Herbert

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Jan 1. 1875

8. AGE: Years 71 | Months 9 | Days 16 | If less than one day: hr. min.

9. Birthplace Clinton Co. Pa (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Thomas Herbert
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Sadie Mobley
15. Birthplace

16 (a) Informant Mrs Lillian Herbert
(b) Address 900 Hilsmont Court

17. (a) Burial (b) Date thereof 10/19/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Lawn
Location Baltimore Md

18 (a) Funeral director Pulliam & Pue
(b) Address 1214 Ft Ave

19 (a) Date received by Registrar OCT 19 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946 at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to October 17 1946 and that I last saw him alive on October 16 1946

Immediate cause of death: Cerebral Hemorrhage — Duration about 4 days

Due to Hypertension

Due to Arteriosclerosis

Other Conditions Myocardiopathy of Heart.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl T Traugott M. D.
Address 1623 E N. Avenue Date signed 10-17-46

VS 150

83a

G44668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44668 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 W. 29th St
(c) Hospital or institution: 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W. 29th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Frick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20th 1852

8. AGE: Years	Months	Days	If less than one day
94	3	27	hr. min.

9. Birthplace Danville, Penna (Town, county, and state)

10. Usual Occupation Retired Postmaster

11. Industry or business Deal Beach N.J.

FATHER 12. Name (Unknown) Frick

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Mildred Sanders

(b) Address 215 W. 29th St. Tel 6891

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)

(c) Cemetery or crematory Danville

Location Montour Co. Penna.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 OCT 18 1946 (Date rec'd, 1946) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1946, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946, to Oct 17, 1946 and that I last saw him alive on Oct 17, 1946.

Immediate cause of death: Bronchopneumonia — Duration: 2 days

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. Weaver M.D.

Address 2902 Huntington Ave. Date signed 10/21/46

M. D.

VS 150

X

G44669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44669

502304.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Summersville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Mason Burdette

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-17-45

8. AGE: Years 1 | Months 1 | Days - | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Alvin M. Burdette
13. Birthplace W. Va.

MOTHER 14. Maiden Name Ruby S. Woods
15. Birthplace W. Va.

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Edgewood
Location West Ingorge

18 (a) Funeral director Wilbur Cook Co.
(b) Address 1217 St Paul St

19 (a) Oct 18 1946 (Date rec'd by registrar) (b) Huntington, W. Va.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 17 1946 at 7.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1946, to Oct. 17 1946, and that I last saw him alive on Oct. 17 1946.

Immediate cause of death: Fever of unknown origin — Duration

Due to: Congenital Mental defect

Other Conditions: Epilepsy

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Sheldon M. D.
Address Date signed (c) 10/19/46

VS 150

44670 Berkebile

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

1178 Registered No. G44670

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Johnstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Gwendolyn Berkebile

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1882

8. AGE: Years 63 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Johnstown Pa (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Lewis L Harris
13. Birthplace Wales England

MOTHER
14. Maiden Name Emma Kephine
15. Birthplace Indiana Co Pa

16 (a) Informant W C Lentz
(b) Address 17 Shady Lane

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month), (day), (year)
(c) Cemetery or crematory Grand View Cem
Location Johnstown Pa.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 OCT. 18 1946 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946, at 6:46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1946, to Oct 17 1946, and that I last saw her alive on Oct 17 1946

Immediate cause of death	Duration
Pulmonary embolism	
Due to Acute intestinal	
Due to duodenal ulcer	
Other Conditions c	

(Include pregnancy within 3 months of death)

Date of operation Oct 13, 1946

Major findings of operation: duodenal ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide c
(b) Date of occurrence c at M
(c) Where did injury occur? c (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? c While at work? (Specify type of place)
(e) Means of injury

23. Signature H Solomon

Address Bon Secours Hosp. Date signed 10/17/46 M. D.

VS 150

X

G44671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G44671 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-1
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lydia C. Affayroux

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband/wife Frank Affayroux

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1879

8. AGE: Years	Months	Days	If less than one day
67	8	10	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name O. Donell
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Emily Sigmund
(b) Address 219 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount & Oliver

18 (a) Funeral director Wellington Bell & Son
(b) Address 1917 St Paul St

19 (a) [illegible] (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1946 at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1946 to Oct 16 1946, and that I last saw her alive on Oct 14 1946

Immediate cause of death: Myocardial Failure — Duration

Due to

Due to

Other Conditions Carcinoma Hepatic Flexure Colon c Metastases

(Include pregnancy within 3 months of death)

Date of operation Sept 14, 1946

Major findings of operation: Carcinoma Hepatic Flex. Colon c Metastases

of autopsy: No above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Perelman
Address Sinai Hospital Date signed M. 10 D. 16/46

G44672

BALTIMORE CITY HEALTH DEPARTMENT X 55E

CERTIFICATE OF DEATH

G44672 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.,
(c) Hospital or institution:
U.S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 196 Clinton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick George Gennett

3 (b) If veteran, name war: --

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Murial Daley

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 11, 1912

8. AGE: Years	Months	Days	If less than one day
34	3	6	hr. min.

9. Birthplace Brooklyn, N.Y.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Army Transport Service

FATHER
12. Name George Gennett
13. Birthplace Brooklyn, N.Y.

MOTHER
14. Maiden Name Helena Poulner
15. Birthplace Brooklyn, N.Y.

16 (a) Informant Records
(b) Address U.S.Marine Hospital, Balto.Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Brooklyn NY

18 (a) Funeral director Oder Funeral Home Inc
(b) Address 4644 York Road.

19 (a) OCT 18 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1946, at 3:23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1946 to Oct. 17 1946 and that I last saw him alive on Oct. 17 1946.

Immediate cause of death Lymphosarcoma, generalized. — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harvey E. Haldeman III asst surg USPHS (R)
Address U.S. Marine Hosp Baltimore-11, Md. Date signed 10/19/46

VS 180

X

AB-9 G44673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1382

Registered No. G44673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 6mo- 23days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1342 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Myers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23- 1920

8. AGE: Years	Months	Days	If less than one day
25	9	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Myers
13. Birthplace Va.

MOTHER
14. Maiden Name Lillie Holmes
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) — (Burial, cremation, or removal) (b) Date thereof 10 20 46 (month) (day) (year)
(c) Cemetery or crematory Asbury Mem. Pk.
Location Baltimore Co., Md.

18 (a) Funeral director J. Preston Lemberg
(b) Address 519 Main St.

19 (a) (Date received by Registrar) OCT 18 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1946, at 5.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23- 1945 to 10-16 1946, and that I last saw h 9X alive on 10- 16- 1946

Immediate cause of death: CARDIAC FAILURE — Duration 30 Minutes

Due to: PULMONARY INFARCTION — Duration 30 min

Due to:

Other Conditions: PULMONARY TUBERCULOSIS Left — Duration yrs.
(Include pregnancy within 3 months of death)

Date of operation Oct 15, 1946

Major findings of operation: Pulmonary tuberculosis. Left

of autopsy: None

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rush E. Nutterville M. D.
Address Balt. City Hosp. Date signed 10-16-46

Huntington Williams, M.D.

X

G44674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44674 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Dorchester Rd.
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Dorchester Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES F. KRASTELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	349-10-9178

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edith A. Krastell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1883

8. AGE: Years	Months	Days	If less than one day
62	11	8	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Buyer
11. Industry or business Butler Bros. retired 5 yrs

FATHER
12. Name John R. Krastell
13. Birthplace Balto., Co., Md.

MOTHER
14. Maiden Name Maul Mulvey
15. Birthplace Balto. Co.

16 (a) Informant Mrs. Edith A. Krastell
(b) Address 3300 Dorchester Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Lillington Williams, M.D. Registrar

OCT 18 1946

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1946 at 4:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 1946; and that I last saw h. alive on 16 Oct 1946.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Hypertension	11 years
Due to: Arteriosclerosis	
Other Conditions: None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Louis P. Hamburger Jr.
Address 120 E. Eutaw Place Date signed 10-18-46

X

G44675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44675 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3325 Woodland Ave.
(c) Hospital or institution: 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 Woodland Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE W. TANKERSLEY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles C. Tankersley
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1873

8. AGE: Years	Months	Days	If less than one day
73	1	6	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: James R. Phoebus
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mr. C. V. Tankersley
(b) Address: 3325 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Park
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 18 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to Oct 15 1946 and that I last saw her alive on Oct 15 1946.

Immediate cause of death	Duration
Arteio Sclerotic	Several years
Cardio Vascular Disease	4 days
Due to Cerebral Hemorrhage	2 days
Due to Broncho Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A. Weinstock M. D.
Address 4603 Pk. Heights Ave. Date signed 10/16/46

VS 150

G44676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G44676.
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & Charles Sts.
(c) Hospital or institution:
Homewood Apts. 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN BIRD BARRETT

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Dr. Robert E. Garrett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1876

8. AGE: Years	Months	Days	If less than one day
70	1	26	hr. min.

9. Birthplace King & Queen Co., Va.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Spottswood Bird
13. Birthplace King & Queen Co., Va.

MOTHER
14. Maiden Name Emma Caroline Dudley
15. Birthplace King & Queen Co., Va.

16 (a) Informant Dr. Robert B. Garrett
(b) Address Homewood Apts.

17 (a) Burial (b) Date thereof 10/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1946, at 6:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 1946.
and that I last saw her alive on 15 Oct. 1946

Immediate cause of death	Duration
Congestive Heart Failure	3 months
Due to Mitral Insufficiency Hypertension	14 years 18 years
Due to	
Other Conditions Cerebral Hemorrhage	9 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. P. Kimmelsteil Jr. M.D.
Address 120 Flanders Place Date signed 10/18/46

G44677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G44677 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto County
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. & Wl Compass Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ferdinand Haney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Esther V. Haney
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 7-12-97

8. AGE: Years 48 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George W. Haney
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Sara Mae Floyd
15. Birthplace Pennsylvania

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) 10/17/46 (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory
Location Altoona Penna

18 (a) Funeral director J. O Mitchell
(b) Address 1900 Eastern Ave

19 (a) OCT 18 1946 (b) [illegible] Registrar
(Date rec'd by reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1946 at 2 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1946 to 10-17 1946, and that I last saw him alive on 10-17 1946.

Immediate cause of death Carcinoma of the larynx — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/17/46

Major findings of operation: Carcinoma of larynx

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Kirkham M. D.
Address Johns Hopkins Hospital signed 10/17/46

VS 150

G44678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

G44678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Asquith (AISQUITH ST)
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Asquith (AISQUITH ST.)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aloina M Neumann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Frank C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26 1865

8. AGE: Years	Months	Days	If less than one day
81	7	19	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Wegandt
13. Birthplace Ger

MOTHER
14. Maiden Name Cathrine Hellman
15. Birthplace Ger

16 (a) Informant Frank C Neumann
(b) Address 1413 Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Balto

18 (a) Funeral director Miller & Leimond Home
(b) Address 2016 Eden St

19 OCT 18 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1946 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1- 1945 to 10-15 1946 and that I last saw her alive on 10-15 1946.

Immediate cause of death: Sarcoma right Clavicle — Duration: 13 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belair Rd Date signed 10-17-46

X

D644679 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44679
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Lamparmouille
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Leading

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1946.

8. AGE: Years	Months	Days	If less than one day
	2	8	hr. min.

9. Birthplace Md -
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard Leading
13. Birthplace Fulton Md.

MOTHER
14. Maiden Name Mary Iris Bozzell
15. Birthplace ? Rogersville, Tenn.

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10 | 19 | 46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns Lutheran
Location Howard Co., Md.

18 (a) Funeral director Easton, Long
(b) Address Elliott City, Md.

19 (a) OCT 18 1946 (b) Hunting for Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1946 at 6:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Oct 17 1946 and that I last saw him alive on Oct 17 1946.

Immediate cause of death: DISEASES OF THE NEWBORN — Duration 1 min.

Due to

Due to

Other Conditions PREMATURITY — Duration LIFE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul M. Hardy

Address Johns Hopkins Hosp. Date signed 10 | 17 | 46
M. D.

VS 150

SIFF

G44680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 737

G44680

Registered No.

1. PLACE OF DEATH: 27-16
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore 15
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3324 Sumter Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Dorothy Siff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1892

8. AGE: Years 54 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Washington D C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Elsie
15. Birthplace Russia

16 (a) Informant Mrs Sydney Sachs
(b) Address 3824 Sumter Ave

17 (a) Removal (b) Date thereof 10-20-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wash. D.C.

18 (a) Funeral director Park Lawn Inc
(b) Address 1439 E Balt St

19 (a) (b)
(Date rec'd by registrar) Registrar

VS OCT 18 1946 Huntington for Millard, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1946 to Oct 17 1946, and that I last saw her alive on Oct 17 1946.

Immediate cause of death
Cardio-respiratory failure
Duration

Due to Acquired Hemolytic Anemia
Duration

Due to etiology undetermined
Duration

Other Conditions
Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Harry T Wilson Jr M.D.
Address St Joseph's Hosp Date signed Oct 17 1946

G44681 — BALTIMORE CITY HEALTH DEPARTMENT — G44681

CERTIFICATE OF DEATH 479

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 N. Kenwood ave.
(c) Hospital or institution: 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5247 N. Lugano ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia – Emelia E. Funke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. F. Funke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 17, 1870

8. AGE: Years 76 | Months 6 | Days 29 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Adolph Funke
(b) Address: 805 McCabe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn
Location: Eastern Avenue

18 (a) Funeral director: Roland L. Fisher
(b) Address: 2112 Dundalk Ave.

19 (a) 10-18-1946 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16, 19 46, at 12 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18, 1946, to Oct. 16, 1946, and that I last saw h[illegible] alive on Oct. 16, 1946.

Immediate cause of death: Pneumonia
Due to: Carcinoma of Lung
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 10/15/46 aug 1 yr.

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: William J. Rosner M.D.
Address: 801 N. Kenwood Ave. Date signed: 10/17/46

VS 150

G44682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered No. G44682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N. Bouldin Street
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Bouldin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Virginia F. Minderlein

3 (b) If veteran, name war
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Phillip
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/17/65

8. AGE: Years	Months	Days	If less than one day
81	4	-	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER	12. Name	? ?
	13. Birthplace	? ?
MOTHER	14. Maiden Name	? ?
	15. Birthplace	? ?

16 (a) Informant Agnes Weber, Daughter
(b) Address 411 N. Bouldin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly + Zeiler Inc
(b) Address 403 S. Wolfe Street

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 18 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH 10/17/ 1946, at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1946 to 10-17 1946, and that I last saw h[illegible] alive on 10-17 1946.

Immediate cause of death: Adenocarcinoma cervical glands. — Duration

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gould M. D.
Address 1416 E Fayette St Date signed 10-18-46

G34683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

486

Registered No. G34683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Hush Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leila C. Snider.

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex F | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George Foster Snider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3 1876

8. AGE: Years 70 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Carroll Co (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel B Eppley
13. Birthplace Frederick Co

MOTHER
14. Maiden Name Mary L Hetterick
15. Birthplace Frederick Co

16 (a) Informant George Foster Snider
(b) Address Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/46 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek
Location Carroll Co

18 (a) Funeral director H Bankard & Son
(b) Address Westminster Md

19 OCT 18 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1946, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1946 to Oct. 18 1946, and that I last saw h[illegible] alive on October 17 19 46.

	Duration
Immediate cause of death: Generalized carcinomatosis	
Due to Metastatic adeno car - cinoma	
Due to Primary adeno car - cinoma of the uterus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert L. Stone M. D.
Address University of Hospital Date signed 10-17-46

VS 150

G44684 Dl. f-55685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G44684 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37d
(e) Length of stay in Baltimore (yrs., mos., or days) 37d

2. USUAL RESIDENCE OF DECEASED: Talbot
(a) State Md (b) County Easton
(c) City or town Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Easton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Rose Kennamer ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 46

8. AGE: Years	Months	Days	If less than one day
	1	32d	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Howard F Kennamer
13. Birthplace Md

MOTHER
14. Maiden Name Geraldine J Jackson
15. Birthplace Md

16 (a) Informant Father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15/46 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md.

18 (a) Funeral director Earl W Stafford
(b) Address Easton Md.

19 (a) 10/15/46 (Date rec'd by registrar) (b) M.H. Nevitt Registrar

OCT 18 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1946, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10- 1946, to 10-13 1946, and that I last saw her alive on 10-13 1946.

Immediate cause of death	Duration
Diarrhea	
Resp. Failure	
Due to Diarrhea	
Due to	
Other Conditions Otitis Media	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James V Mercer Jr. M. D.
Address Mercy Hosp Date signed 10-13-46

X

AB-89698 G44685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G44685 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

19-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. 1mo. 9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Rapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6-1881

8. AGE: Years	Months	Days	If less than one day
65	9	10	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Repp (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Lehr (D
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-1946 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM
Location

18 (a) Funeral director CHARLES P TOWELL
(b) Address 2427 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 OCT 18 1946 Evelington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16- 1946, at 11PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1944 to 10-16 1946, and that I last saw him alive on 10-16 1946

Immediate cause of death Heart Failure — Duration
Arteriosclerotic Heart Disease

Due to

Due to

Other Conditions Examined at autopsy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac Dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 10/16/46

G44686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G44686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 No Collington Ave
(c) Hospital or institution: C-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 27 No Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Stahn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Resa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 74 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Michla
15. Birthplace Russia

16 (a) Informant Benj Fahn
(b) Address 27 No Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-46 (month) (day) (year)
(c) Cemetery or crematory Location Hebrew Mt Carmel

18 (a) Funeral director Jack Levin Co
(b) Address 1809 E Baltimore St

OCT 18 1946 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1946, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945 to 10-17-1946 and that I last saw h[illegible] alive on 10-17-1946

Immediate cause of death: Carcinoma of left upper lung
Due to: Clw. cholelithiasis Chr. cholecystitis
Due to:
Other Conditions: general arteriosclerosis
(Include pregnancy within 3 months of death)

Duration: 1 Months 1945 1

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Michelson M. D.
Address 2230 Eutaw Pl Date signed 10/18/46

VS 150

G44687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N-3
(b) Street address
(c) Hospital or institution: St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 A
(e) Length of stay in Baltimore (yrs., mos., or days) 30 A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY FRANK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife John C. Frank
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-1891

8. AGE: Years	Months	Days	If less than one day
53	4	21	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Packer

11. Industry or business

FATHER
12. Name Lorenzo Lee Kendall
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Dora Kolb
15. Birthplace Balto. Md

16 (a) Informant Anna Kerry
(b) Address 401 New Kirk St.

17 (a) Burial (b) Date thereof 10-21-46
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) 10 18 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/46 19..., at 5:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 10/17/46

G44688 BALTIMORE CITY HEALTH DEPARTMENT G44688
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4113 Morrison Court
(c) Hospital or institution: 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4113 Morrison Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis J. Ordakowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25-1886

8. AGE: Years 60 | Months 1 | Days 23 | If less than one day: hr. min.

9. Birthplace Carpenter Poland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Felix Ordakowski

13. Birthplace Poland

MOTHER 14. Maiden Name Catherine Brozek

15. Birthplace Poland

16 (a) Informant Milton Ordakowski

(b) Address 4112 Grace Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21-46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location A.A. Co.

18 (a) Funeral director Wm. L. Fialkowski

(b) Address 2907 Eastern Ave

19 (a) (b) Registrar

OCT 18 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1946 to Oct 17 1946 and that I last saw alive on Oct 17 1946.

Immediate cause of death	Duration
Coronary occlusion	
Due to Hypertension	
cardio vascular dis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. W. Kuster MD

Address 302 Palazzo Date signed 10/17/46

X

No. G44689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible] HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Asbury (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Seeling

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 2 158-01-3988

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia A Seeling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-95

8. AGE: Years 51 | Months — | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Bus Driver

11. Industry or business

FATHER
12. Name Chas Seeling
13. Birthplace Penna

MOTHER
14. Maiden Name Eliz A Chenoweth
15. Birthplace Balto County Md

16 (a) Informant
(b) Address [illegible] HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 | 21 | 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7461 Belair Rd

19 (a) [illegible] (Date rec'd by local reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1946 at 5 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Dubois M. D.
Address Johns Hopkins Hospital Date signed 10-17-46

VS 150

For H. B. Hayden - by Howard J. Clements, M.D.

C44690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. C44690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11mo- 25days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Margaret Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25- 1924

8. AGE: Years	Months	Days	If less than one day
21	10	30 20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clark Cunningham
13. Birthplace Md.

MOTHER
14. Maiden Name Mildred Green
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry

19 (a) (Date rec'd by registrar) (b)

OCT 18 1946

Burial for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15- 1946, at 11.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25- 1945 to 10-15 1946 and that I last saw her alive on 10-15 1946

Immediate cause of death: Pulmonary Tuberculosis, Far advanced — Duration 3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hospitals Date signed 10-16-46

X

G44691 ✓ G44691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St 25-4
(c) Hospital or institution: South Balto Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 371 Brooklyn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower.

6 (b) Name of husband or wife Alberta La Fontaine 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16 - 187x

8. AGE: Years	Months	Days	If less than one day
74	8	29	hr. min.

9. Birthplace Prince Geo. Co. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B & O.

FATHER
12. Name John P. Webster
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Monroe
15. Birthplace Md

16 (a) Informant Mrs Barbara Finley
(b) Address 371 2 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.19.46. (month) (day) (year)
(c) Cemetery or crematory Laurel Park
Location Frederick Ave

18 (a) Funeral director J. J. Foley Sons
(b) Address 1311 Light St.

OCT 18 1946 (Date rec'd) by Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1946 at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1946 to 10/15 1946 and that I last saw him alive on 10/15 1946

Immediate cause of death: Uremia - Due to Chronic Glomerulo-nephritis

Duration

Due to

Due to

Other Conditions Pneumonia - Right upper lobe

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert H. Saunders M.D.
Address 1211 Light St Date signed 10-15-46

VS 150

1216

G44692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G44692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N. Milton ave
(c) Hospital or institution:
6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Milton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph H. Chambers.
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1876

8. AGE: Years 70 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Postmaster

11. Industry or business

FATHER
12. Name William Chambers
13. Birthplace England

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Ireland

16 (a) Informant Catherine Chambers.
(b) Address 22 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1980 Fortune Ave

OCT 18 1946 (b) Huntington Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10- 1946 to 10-17-1946, and that I last saw him alive on 10-17-1946

Immediate cause of death: Acute Myocardial Failure — Duration 1 week

Due to Arteriosclerosis — 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry B. Mosey M.D. M. D.
Address 448 N. Lafayette ave Date signed 10-18-46

VS 150

X

4693 B C# D58219

BALTIMORE CITY HEALTH DEPARTMENT ✓ G44693

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH: 27-5
(a) Baltimore City, Maryland
(b) Street address DuKaland + Rayner Ave.
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12a
(e) Length of stay in Baltimore (yrs., mos., or days) 12a.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ~~City or town~~ Street 3114 Woodhome Ave
(If outside city or town limits, write RURAL and give town)
(d) ~~Street No.~~ City Balto. 14.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Duane MicKey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1946

8. AGE: Years | Months | Days | If less than one day 17 hr. 16 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry S. Mickey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Blanche V. Nusbaum
15. Birthplace Taneytown, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY OCT 18 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

OCT 8 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1946, to Oct 7 1946, and that I last saw h alive on 19

Immediate cause of death Cardiac Failure — Duration

Due to Unknown

Due to

Other Conditions Prematura

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph M. Koch

Address Mt. Pleasant Hospital Date signed Oct 7 46

VS 190

X

G44694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G44694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 E 35th St
(c) Hospital or institution:
9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 E 35th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalia Nonnemann

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Henry Nonnemann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1. 1867

8. AGE: Years	Months	Days	If less than one day
79	7	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Heinrich Donber
13. Birthplace Germany

MOTHER
14. Maiden Name Appolonia Dyth
15. Birthplace Germany

16 (a) Informant Mrs Wilhelm Nonn
(b) Address 800 E 35th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros Co
(b) Address 1217 E Lond St

OCT 18 1946 (Date received by local registrar) (b) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1946, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 July 1946, to 16 Oct 1946 and that I last saw h er alive on 16 Oct 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerotic Cardio Vascular Disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W Edmonds M. D.
Address 2746 The Alameda Date signed Oct 17 46

VS 150

G44695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G44695
Registered No.

HB # 104923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 Manse Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beale Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1870

8. AGE: Years 76 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Sara Flethcher
15. Birthplace Md.

16 (a) Informant: Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct 20, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150 OCT 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1946; 11:AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1946 Oct. 16 1946 and that I last saw h im alive on Oct. 16 1946

Immediate cause of death: Myocardial failure — Duration:

Due to Hypertensive Cardio Vascular Disease — 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Coleman Jr M. D.
Address Balt. City Hosp Date signed 10/18/46

X

G44696 BALTIMORE CITY HEALTH DEPARTMENT ✓ R G44696

D56346 CERTIFICATE OF DEATH 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Parent ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	boy

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-46

8. AGE: Years	Months	Days	If less than one day
	1	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Curtis Parent
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Barnes
15. Birthplace North Carolina

16 (a) Informant Nurse
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1946, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1946, to 10-16 1946, and that I last saw h[illegible] alive on 10-16 1946.

Immediate cause of death	Duration
DIARRHOEA OF THE NEWBORN	3 wks
Due to	
Due to	
Other Conditions PREMATURITY	1 wk

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H Harden
Address JOHNS HOPKINS HOSP Date signed M. 10 D. 18 46

VS-450 X

G44697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a G44697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1621 W Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Williams

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Mary Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1884

8. AGE: Years	Months	Days	If less than one day
61 62	10	3	hr. min.

9. Birthplace Watterton N.C.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Williams
(b) Address 1621 W. Franklin St.

17 (a) Shipped (b) Date thereof Oct. 18 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Franklin Va.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Lexington Hill Registrar

VS 150 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 19 46, at 3:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 19 46 to 10/17 19 46
and that I last saw h alive on 10/17 19 46

Immediate cause of death Cerebral Hemorrhage — Duration 2 days
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10/18/46

X

G44698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G44698 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 S. ROSE ST
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME APOLONIA SWISTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Joseph (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/26/1882

8. AGE: Years	Months	Days	If less than one day
64	6	18	hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Anna Hofmanski
(b) Address 504 S. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/1946 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gepmont Hill Rd

18 (a) Funeral director John M. Sheber
(b) Address 401 S. Chester St.

19 (a) OCT 18 1946 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1946 at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1946 to Oct 15 1946 and that I last saw h[illegible] alive on Oct 15 1946.

Immediate cause of death	Duration
Hypertension & Myocarditis	2 mos
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy D. Lyford M. D.
Address 432 S. Patterson Park Date signed 10/18/46

VS 150

X

G44699 KONOP ✓ G44699

BALTIMORE CITY HEALTH DEPARTMENT

F 27726 **CERTIFICATE OF DEATH** 115c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 26-6
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution:
The Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6708 Bessemer Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME
Konop. Patricia Ann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife none.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1941

8. AGE: Years	Months	Days	If less than one day
5	6	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name Konop, Frank
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Appel, Beatrice
15. Birthplace Baltimore Md.

16 (a) Informant Mother
(b) Address 6708 Bessemer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director John P. Fisher
(b) Address 407 S. Chester St.

19 (a) OCT 18 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 October 1946 at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Oct 1946 to 15 Oct 1946 and that I last saw h.. alive on 15 Oct 1946.

Immediate cause of death Surgical Shock — Duration

Due to T + A

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 15 Oct 1946
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Kohlerman M. D.
Address The Church Home + Hosp. Date signed 15 Oct 1946

VS 190

G44700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G44700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4300 Glenmore Avenue
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Glenmore Avenue
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -------

3 (a) FULL NAME: Arthur James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara Elizabeth Jones

6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1887

8. AGE: Years 59 | Months 0 | Days 4 | If less than one day --hr. --min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Vending Machine Busine

FATHER: 12. Name: Matthew James Smith
13. Birthplace: Baltimore, Maryland

MOTHER: 14. Maiden Name: Emma Lambdin
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Matthew James Smith, Jr.
(b) Address: 602 Anneslie Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director: H. W. Meeks and Son
(b) Address: 805 N. Calvert Street

19 (a) (Registrar) (b) Huntington Williams, M.D.

OCT 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1946, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946, to Oct 16 1946, that I last saw him alive on Oct 16 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr.

Due to: Cerebral Thrombosis — 9 mo

Due to: Arteriosclerosis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Jos. Harding M. D.

Address 4816 Belair Rd Date signed 10/17/46

VS 150

G44701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G44701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-7
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Ba Hi more
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Lawrence Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-1403

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1885

8. AGE: Years	Months	Days	If less than one day
61	4	4	hr. min.

9. Birthplace Connecticut (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name Daniel Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Victoria R Stassatt
15. Birthplace Scotland

16 (a) Informant Mr. Francis Sullivan
(b) Address 4011 Roland Ave, Balto 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-46 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Balto Md

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1946, at 6.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1946, to Oct 17 1946, and that I last saw him alive on Oct 17 1946.

Immediate cause of death	Duration
Myocardial infarction	
Due to Coronary Thrombosis	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Freeman Jr. M.D.
Address Union Memorial Hosp Date signed Oct 17 1946

X

~~4702~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

Registered No. G 4702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 E. Federal Street
(c) Hospital or institution: E-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 E. Federal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Matilda Chenoweth

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Washington B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1866

8. AGE: Years	Months	Days	If less than one day
80	7	3	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business old home

MOTHER'S MAIDEN NAME
12. Name Jacob Keller
13. Birthplace Balto. Co., Md.
14. Maiden Name Margaret A. Hamilton
15. Birthplace Balto. Co., Md.

16 (a) Informant Norman U. Chenoweth (Son)
(b) Address 2000 E. Federal St.

17 (a) Burial (b) Date thereof Oct 21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Thomas
Location Garrison Forest

18 (a) Funeral director Frank H. Merrill
(b) Address Pikesville, Maryland

OCT 18 1946 Huntington Williams M.D.
(Date rec'd by Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1946, at 8 20 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Chen death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Hypertension

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Thompson M.D.
Medical Examiner.
Date signed 10-18-46

VS 151

G44703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 c

Registered No. G44703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2746 Riggs Ave
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2746 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married.

6 (b) Name of husband or wife Sarah A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1895.

8. AGE: Years	Months	Days	If less than one day
51.	2	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business Home Security Life Co

FATHER
12. Name James A. Griffin
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Fahey
15. Birthplace Baltimore

16 (a) Informant Mrs Sarah A Griffin
(b) Address 2746 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 4300 Frederick Road

18 (a) Funeral director Joseph Sommerville Sons
(b) Address 908-03 Pennsylvania Ave.

19 (a) (Date received by registrar) (b) Registrar

OCT 18 1946 Huntington Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16. 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1946 to Oct 16 1946 and that I last saw h alive on Oct 16 1946.

Immediate cause of death	Duration
Carcinoma cervical glands	
Due to Pulmonary Carcinomatosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Biopsy Cervical

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. E. Neadle M. D.

Address 7314 - York Rd. Date signed 10/19/46

G44704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44704 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 Ramsey St
(c) Hospital or institution: 21-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Ramsey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Clark

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Evelyn M. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1892

8. AGE: Years	Months	Days	If less than one day
54	5	25	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Car Loader
11. Industry or business Railway Express Exchange

FATHER
12. Name William Clark
13. Birthplace Va.

MOTHER
14. Maiden Name Laura Wooster
15. Birthplace Norfolk Va

16 (a) Informant Evelyn M. Vessels
(b) Address 921 Ramsey St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 2930 Fredericks Ave

18 (a) Funeral director John J Gowan & Son
(b) Address 901 & 903 Hollins St.

19 (a) (Date received by registrar) (b) Registrar

OCT 18 1946

VS 190

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1946, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 May 1946 to 17 Oct. 1946, and that I last saw h him alive on 17 Oct 1946

Immediate cause of death	Duration (Immediate)
Coronary Thrombosis.	
Due to Coronary heart disease	(Antecedent)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
If autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Charles J. Tamasello
Address 910 W. Lombard St Date signed 18 Oct 46 M. D.

X

G44705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G44705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd.
(c) Hospital or institution: Shriner Nursing Home 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3731 Columbus Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE ANDERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Charles Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1861

8. AGE: Years	Months	Days	If less than one day
84	10	29	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hans Anderson
13. Birthplace Norway

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. B. Iverson, daughter
(b) Address 3731 Columbus Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received) OCT 18 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 to Oct 16 1946.
and that I last saw h alive on 19
Immediate cause of death: Cerebral Hemorrhage — Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore H. Calvin M. D.
Address 1 E. Pleasant St. Date signed 10-19-46

VS 150

G44706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 Evesham Ave
(c) Hospital or institution:
– 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Evesham Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA LOUISE SIEMERS STIDHAM

3 (b) If veteran, name war: –

3 (c) Social Security Account No. 217-07-9650

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	Married

6 (b) Name of husband or wife FRANK STIDHAM
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 25 1904

8. AGE: Years	Months	Days	If less than one day
31	10	22	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation BOOKKEEPER
11. Industry or business BANK (Towson Nat'l.)

FATHER
12. Name GEORGE W. SIEMERS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name AUGUSTA BARTHOLOMAEI
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. GEORGE W. SIEMERS
(b) Address 422 EVESHAM AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 18 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 October 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Oct., 1946, to 17 Oct 1946, and that I last saw h.e.r. alive on 17 Oct 1946.

Immediate cause of death: SUBARACHNOID HEMORRHAGE — Duration 2d Hrs.

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE — 4 YEARS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Rd. Date signed 17 Oct '46

VS 250

X

4707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G44707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 840 Harlem Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PARTHENIA MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Vernon Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Blackstone, Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

12. Name Jacob. Woodston
13. Birthplace Va

14. Maiden Name Nannie Woodston
15. Birthplace Va.

16 (a) Informant Vernon Morgan
(b) Address 840 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/46 (month) (day) (year)
(c) Cemetery or crematory Celo Creek Cemetery
Location Blackstone, Va.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Eastlyane

OCT 18 1946 (Date rec'd by Registrar) Livingston Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/46 19 , at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic myocarditis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John A. Ward M.D.
Medical Examiner.
Date signed 10/17/46

X

4708

502439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44708

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Randolph
(c) City or town Bassity
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Duay Hammond.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-31-37.

8. AGE: Years 9 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clinton Hammond.
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mabel Taylor
15. Birthplace W. Va.

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 1946 (month) (day) (year)
(c) Cemetery or crematory [illegible] W. Va.
Location [illegible] W. Va.

18 (a) Funeral director Wendell Humphreys
(b) Address 6067 Harford Rd.

19 (a) Date received ~~OCT 19 1946~~ (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 18 1946, at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct- 10 1946 to Oct- 18 1946, and that I last saw him alive on Oct- 18 1946,

Immediate cause of death: Tuberculous Meningitis — Duration: 4 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 1946

Major findings of operation: Tuberculous Meningitis

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur M Laing

Address Johns Hopkins Hosp. Date signed 10/18/46

X

G44709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1794

Registered No. G44709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 St. Paul st.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 St. Paul st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Maria Carter
(b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex: Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow Married
(b) Name of husband or wife Wm Allen Carter
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 7-7-1857
8. AGE: Years 89 Months 3 Days 11 If less than one day hr. min.
9. Birthplace Champagne Co. Ohio (Town, county, and state)
10. Usual Occupation None
11. Industry or business
12. Name Ebenezer T Roseberry
13. Birthplace Champagne Co., Ohio
14. Maiden Name ? ? Tway
15. Birthplace Champagne Co. Ohio
16 (a) Informant Miss Alice L. Carter (daughter)
(b) Address 3019 St. Paul St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)
(c) Cemetery or crematory Shawnee
Location Shawnee Ohio
18 (a) Funeral director STEWART & HOWEN COMPANY
(b) Address
19 (a) OCT 19 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1946, at 10.05 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Nicotine Poisoning

Due to Bench Leaf (#40).

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 10-18-46

VS 191

X 152

G44710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G44710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Bennhaus Road, Govans
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Benninghaus Road, Govans (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina M. Mergl

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Joseph Mergl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1891

8. AGE: Years	Months	Days	If less than one day
55	3	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Joseph Blum
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Reilly
15. Birthplace Maryland

16 (a) Informant Joseph Mergl
(b) Address 611 Benninghaus Road, Govans

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (b) OCT 19 1946 [illegible] for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1946, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 1946 to 17 Oct. 1946, and that I last saw h[illegible] alive on 17 Oct. 1946

Immediate cause of death	Duration
Cerebral Hemorrhage with hemiplegia (R)	1 mo.
Due to Hypertension-Cardio vascular renal disease	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed 18 Oct. 1946

VS 150

X

G44711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G44711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1758 Montepelier St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1758 Montepelier St.
(If rural give location)
Montpelier
(e) If foreign born, how long in U. S. A.? years

3. (a) FULL NAME Louis F. Knipp
(b) If veteran, name war
(c) Social Security Account No. 213-09-5924

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
(b) Name of husband or wife Elsie D. Knipp
6 (c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) April 5. 1877
8. AGE: Years 69 Months 6 Days 13 If less than one day hr. min.
9. Birthplace Baltimore, Md.
(City, county, and state)
10. Usual Occupation Retired
11. Industry or business

12. Name Christopher Knipp.
13. Birthplace Germany
14. Maiden Name — Miller
15. Birthplace Baltimore, Md

16 (a) Informant Charles R. Knipp
(b) Address 2523 Hamilton Ave
17 (a) Burial (b) Date thereof 10/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave
18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road.
19 (Date received by registrar) OCT 19 1946 (Signature of Registrar) Huntington Williams, M. D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1946, at 8 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1946, to 10-15 1946 and that I last saw h[illegible]ive on 10-15 1946.

Immediate cause of death
Carcinoma Stomach — Duration 9 Months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C. W. Peake M. D.
Address 4502 Harford Rd Date signed 10-15-46

~~44712~~ AB-92747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. G44712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr 6mo 28days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homeless- 4940 Eastern Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Arthur Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20- 1885

8. AGE: Years	Months	Days	If less than one day
63	3	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel J. Clark (D
13. Birthplace Md.

MOTHER
14. Maiden Name Lucinda Lynn (D
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm Cey H Holland
(b) Address 1431 Druid Hill Ave

19 (a) Date received OCT 19 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1946 at 2.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24- 1946 to 10-16 1946, and that I last saw h in alive on 10-16 1946.

Immediate cause of death
Angiosarcoma, Terminal — Duration 3 Days
Due to
Due to
Other Conditions Sepsis Decubitus — 10 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balto City Hosp Date signed 10/16/46

107

C14713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C14713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 N Chapel
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 N Chapel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Straka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1868

8. AGE: Years 77 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Joseph Plucinn
13. Birthplace Czeko Slovakia

MOTHER
14. Maiden Name Emma
15. Birthplace " "

16 (a) Informant Anna Kahn
(b) Address 1041 N Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19/46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Balto Md

18 (a) Funeral director Uelland Funeral Home
(b) Address 2008 Orleans St

19 (a) Date received OCT 19 1946 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct 17 1946 and that I last saw h[illegible] alive on Oct 17th 1946

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions Congestion of Lungs Colon of L. Ulcers.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I Lane Trapnell

Address 1623 E. N. Avenue Date signed 10-18-46

VS 180

44714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 2/61

G44714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 N Bond St.
(c) Hospital or institution: ••••••••••
(d) Length of stay in hospital or inst. (yrs., mos., or days) •••
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 N Bond ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Emmit Newton Millert.

3 (b) If veteran, name war ••••••
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida Elizabeth (Clark
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 13, 1873
8. AGE: Years 73 | Months 1 | Days 4 | If less than one day hr. min.
9. Birthplace Charlottesville Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Painter & Decorator

FATHER
12. Name Charles Millert
13. Birthplace Charlottesville Va.

MOTHER
14. Maiden Name Henrietta Pierce
15. Birthplace Charlottesville Va.

16 (a) Informant Mrs Ida E Millert (Wife)
(b) Address 1821 N Bond ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 /21 / 46 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cemetery
Location Charlottesville Va.

18 (a) Funeral director J Melville Jenkins
(b) Address 2713 Kirk Ave.

19 OCT 19 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946, at 4 30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1946, to Oct 17 1946, and that I last saw h••• alive on Oct 16 1946

Immediate cause of death: Bronchopneumonia — Duration 2d.
Due to Desseches Mellelu — 7d.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J F A Stevens
Address 2878 Hartford Av Date signed 10, 19, 46

VS 180

G44715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G44715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Whittier Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Whittier Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Feikin

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-5696 B

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Cecelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1873

8. AGE: Years	Months	Days	If less than one day
73	6	26	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Furrier

FATHER
12. Name Gershen Feikin
13. Birthplace Russia

MOTHER
14. Maiden Name Nettie Mezon
15. Birthplace Russia

16 (a) Informant Cecelia Feikin
(b) Address 2215 Whittier Ave

17 (a) Burial (b) Date thereof Oct, 20, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Cem
Location Chizuk Amuno Con Rogers Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received by Registrar Oct 21 1946 (b) Registrar's signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION 11.00

20. DATE OF DEATH October 16 1946 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to 10/16 19 46 and that I last saw h[illegible] alive on 10/16 19 46

	Duration
Immediate cause of death: Cerebral + Generalized Sclerosis	?
Cerebral Hemorrhage	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10/21/46

VS 150

4716 D.C.#-54506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1158

Registered No. C44716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 W CLEMENT ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 W CLEMENT ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME INFANT OF GEO & ANNA ROLF

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 17-46

8. AGE: Years | Months | Days | If less than one day 14½ hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER | FATHER

12. Name GEO ROLF

13. Birthplace BALTIMORE MD

14. Maiden Name ANNA BRAUN

15. Birthplace BALTIMORE MD

16 (a) Informant GEO ROLF

(b) Address 124 W CLEMENT ST

17 (a) BURIAL (b) Date thereof Oct 19-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL CEM

Location BALTO MD

18 (a) Funeral director Bernard C Hoale

(b) Address 121 E West St

OCT 19 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1946 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946 to Oct 18 1946 and that I last saw h alive on Oct 18 1946

Immediate cause of death Respiratory Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R E Elliott M. D.

Address 1072 W. West St Date signed 10/18/46

VS 150

X

14717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G44717 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: "
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 S. Paca St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella C. Benson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife William C. Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 8, 1887

8. AGE: Years 59 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name Henry Clayton
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Dorsey
15. Birthplace Maryland

16 (a) Informant Mrs Ella C. Benson
(b) Address 1011 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Loch Raven Blvd.

18 (a) Funeral director John J. Gorman & Son
(b) Address 1641-43 Hollins St.

19 (a) Date received by local registrar OCT 19 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1946; at 5 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3, 1946 to Oct 17, 1946 and that I last saw h.e.r. alive on Oct 17, 1946.

Immediate cause of death Cardiac Failure — Duration

Due to Coronary Occlusion

Due to Coronary Heart Disease & Cardiac Decompensation

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry P. Hill, M.D.
Address Amer. Hosp. Date signed 10/23/46

VS 150

14718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G44718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 Northway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Northway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY T. FREEMAN

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 216-10-1024

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1880

8. AGE: Years 65 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Lapsley Interstate Shade Cl Co.

FATHER
12. Name Thomas Freeman
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Emma F. Latimer
15. Birthplace Charles Co., Md.

16 (a) Informant Mr. Norman R. Freeman
(b) Address 210 Northway 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory Christ Church
Location Port Republic, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 19 1946 (Date rec'd by registrar) (b) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 18 1946 and that I last saw him alive on Oct 17 1946.

Immediate cause of death: Coronary Occlusion
Due to: Arteriosclerosis
Due to:
Other Conditions:

Duration
—

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilmer Ford
Address 30 E. Preston St. Date signed 10/19/46 M. D.

VS 150

X

44719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G44719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 BRISCOE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 BRISCOE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MARGARET BRANDT

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE
4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband: FREDERICK E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) OCT. 29, 1870
8. AGE: Years 75 | Months 11 | Days 20 | If less than one day hr. min.
9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation HOUSE WIRK
11. Industry or business OWN HOME

FATHER
12. Name ANDREW L. DAUM
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY HOHL
15. Birthplace GERMANY

16 (a) Informant: PAUL E. BRANDT
(b) Address 506 W. HAMBURG ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM.
Location EDMONDSON AVE

18 (a) Funeral director Joseph T. Gontrum, Jr.
(b) Address 414 N. Franklintown Rd.

19 (a) OCT 19 1946 (Date rec'd by registrar) (b) Registrar Wilmington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 17 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 17 1946. and that I last saw her alive on 10/17 1946.

Immediate cause of death: CARCINOMA of left lung — Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2210 W. Lake Date signed 10/19/46

VS 190

ave X

44720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G44720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Scott St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Scott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John George Gregner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louise Gregner | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1863

8. AGE: Years 83 | Months 5 | Days 9 | If less than one day: hr. min.

9. Birthplace: Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Gregner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Mickling
15. Birthplace Germany

16 (a) Informant: Mrs Edward Gregner
(b) Address 624 Scott St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)
(c) Cemetery or crematory: London Park Cem
Location: Frederick Ave

18 (a) Funeral director: John D Miller Inc
(b) Address 2435 E Oliver St

19 (a) Oct 19 1946 (Date received by local registrar) (b) Huntington Wilkins, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1946; at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1946, to Oct 17 1946, and that I last saw h his alive on Oct 17 1946.

Immediate cause of death: Bronchopneumonia — Duration: 2 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Eschmann M D

Address 1914 North Ave Date signed 10/18/46

X

G44721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G44721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Springdale Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Juren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Herald

13. Birthplace Russia

MOTHER 14. Maiden Name Lucka

15. Birthplace Russia

16 (a) Informant Eva Juren

(b) Address 3712 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-46 (month) (day) (year)

(c) Cemetery or crematory

Location Norfolk Va

18 (a) Funeral director Deeck Lewis Inc

(b) Address 1429 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1946, at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946, to Oct 18 1946, and that I last saw h[illegible] alive on Oct 18 1946.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Coronary

Due to

Other Conditions Arteriosclerosis Hypertension Heart Disease Angina

(Include pregnancy within 3 months of death) Gall

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 10/19/46 M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

X

G44722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4406 Belair Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie E. Russell.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph J. Russell 6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) July 19 1896

8. AGE: Years	Months	Days	If less than one day
50	2	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John L. Warnes.
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Russell
15. Birthplace Md.

16 (a) Informant Joseph J. Russell.
(b) Address 4406 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Ave.

18 (a) Funeral director L. Hemsley Wilmer
(b) Address 3610-12 Gertrude Ave.

19 (Date received by registrar) Arlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1946, at 9 P M

21. I certify that death occurred on the date above stated that I attended deceased from Aug 1946, to Oct 1946, and that I last saw h[illegible] alive on Oct 15 1946.

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 3217 Harford Road Date signed 10-19-46

VS 150

4011 G44723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G44723 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Reedville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Russell Hey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jane Hey — 6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 9-18-94

8. AGE: Years	Months	Days	If less than one day
52	1	1	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation salesman
11. Industry or business

FATHER
12. Name Bascom Hey
13. Birthplace Virginia

MOTHER
14. Maiden Name Hattie Morris
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22 46 (month) (day) (year)
(c) Cemetery or crematory Kilmarnock Va
Location

18 (a) Funeral director George A. Farley
(b) Address Belt & Fayette

19 (a) (Date rec'd by registrar) (b) [illegible] Washington Williamsburg Va

OCT 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-1946, at 7 22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1946 to 10-19 1946, and that I last saw h alive on 10-19 1946.

Immediate cause of death	Duration
Acute myocardial infarction, anterior.	
Due to Coronary arteriosclerotic heart disease & thrombosis	
Due to	
Other Conditions Questionable hiatus hernia (Include pregnancy within 3 months of death)	

Date of operation 10/18/46
Major findings of operation: Pheumicorhesis, left
of autopsy: Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. D. Speed III
Address Johns Hopkins Hosp. Date signed 10/19/46

VS 150

G44724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

G44724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Mt Sinai Hospital
(c) Hospital or institution:
Baltimore- Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1349 Cooksie Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS (F) KANTENK (KAUTEN) Jr.

3 (b) If veteran, name war: WORLD WAR 2
3 (c) Social Security Account No. 214-12-0430

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Helen Kanten
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) June 30th 1922

8. AGE: Years 24 | Months 9 | Days 28 | If less than one day: hr. min.

9. Birthplace Md. (town, county, and state)
10. Usual Occupation Ship Fitter
11. Industry or business Bethl. Steel Co.

FATHER:
12. Name Nicholas Kanten
13. Birthplace Hungary

MOTHER:
14. Maiden Name Elizabeth Mooss
15. Birthplace Hungary

16 (a) Informant Helen Kanten
(b) Address 1349 Cooksie St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21st 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dill.
(b) Address 1501 E Fort Ave

19 1946 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17. 1946 at 9.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hemorrhage and shock from lacerations of left leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-17-46 at 1.30 p. M. 214/2
(b) Where did injury occur? Key Highway-
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by crane

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10-18-46

VS 191

G44725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46

Registered No. G44725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Street.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME W. Harry Webster

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife: Mary S Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	3	27	1	

9. Birthplace Aldy Harford Co Md
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

BORN | PARENTS
12. Name B Frank Webster
13. Birthplace Harford Co Md
14. Maiden Name Henrietta Aldy
15. Birthplace Harford Co Md

16 (a) Informant Mrs Mary S Webster
(b) Address Street Harford Co Md

17 (a) Burial (b) Date thereof Oct 22 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Emory
Location Street Harford Co Md

18 (a) Funeral director Charles C Hurst
(b) Address Darrellsville Md.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

OCT 20 1946
VS-160

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19, 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7, 1946 to Oct 19, 1946 and that I last saw him alive on Oct 19 1946

Immediate cause of death: Circulatory failure — Duration
Due to Carcinoma of rectum.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Ca of rectum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Agnew
Address Md. General Hosp. Date signed 10/19/46

X

G44726 BALTIMORE CITY HEALTH DEPARTMENT G44726

CERTIFICATE OF DEATH 10

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N. Linwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Linwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Kozik

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19 1940

8. AGE: Years	Months	Days	If less than one day
5	11	25	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Kozik
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Chmielewski
15. Birthplace Balto. Md.

16 (a) Informant Peter Kozik
(b) Address 715 N. Linwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Balto. County

18 (a) Funeral director John M. Welby
(b) Address 401 S. Chester Street

19 (a) Date received by Registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946, at 5 P.M.

21. I certify that death occurred on the day above stated, that I last attended deceased from Oct 16 1946 to Oct 17 1946 and that I last saw h[illegible] alive on Oct 17/46

Immediate cause of death Diphtheria

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Oct 18/46

23. Signature Leo F. Kurlacke, M.D.
Address 126 S. Broadway Date signed Oct 18/46

VS 150 Huntington Williams, M.D.

G14727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G14727 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Linden Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1508 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leona Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day, hr.	min.
52				

9. Birthplace Port Madilda Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Merryman
13. Birthplace Penn

MOTHER
14. Maiden Name Sarah Kelly
15. Birthplace Penn

16 (a) Informant Gates Carson
(b) Address 1508 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Pleasant Cem
Location Port Madilda - Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St
(c) 1946 (Date rec'd by registrar) (b) Lexington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 18 - 1946 at 4:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12/46 19 to 10/18/46 19 and that I last saw h er alive on 10/12/46 19

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Hypertensive cardio-Renal disease & Diabetes	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Culverhouse M.D.

Address 1901 Eutaw Place, Date signed 10/19/46

J. B. Culverhouse

VS 150

G44728 BALTIMORE CITY HEALTH DEPARTMENT G44728

CERTIFICATE OF DEATH 479

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3657 Cottage Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, give name of RURAL area or of town)
(d) Street No. 3657 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Buckman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Herman

13. Birthplace Russia

MOTHER 14. Maiden Name Chia

15. Birthplace Russia

16 (a) Informant Joseph Buckman

(b) Address 3657 Cottage Ave

17 (a) Burial (b) Date thereof 10-20-46 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Location Rhoda Rd & Hamilton Ave

18 (a) Funeral director Jack Levine Inc

(b) Address 1109 E Baltimore St

19 (a) 20 1946 (Date rec'd by registrar) Huntington Wilson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 18 - 1946, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1939 to 10/18 1946, and that I last saw h[illegible] alive on 10/18 1946.

Immediate cause of death: Carcinoma of Lung — Duration 1927

Due to:

Due to:

Other Conditions Diabetes Mellitus — 1937

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 2316 Eutaw Pl Date signed 10/19/46

VS 150

G44729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44729 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Boundary.
(c) Hospital or institution:
Church Home + Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days. 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3518 Barrington Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Frederick Champagne.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mrs Louise Champagne

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1868

8. AGE: Years	Months	Days	If less than one day
78 26	0	10	hr. min.

9. Birthplace Michigan.
(Town, county and state)
10. Usual Occupation Retired
11. Industry or business Retired.

MOTHER | FATHER
12. Name Unknown
13. Birthplace Unknown
14. Maiden Name Unknown.
15. Birthplace Unknown

16 (a) Informant Geo. Betherton
(b) Address 1508 Lexington Parkway

17 (a) Removal (b) Date thereof 10/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bay City
Location Michigan

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Filed Oct 20 1946 Worthington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1946, at 7 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946 to Oct 19 1946, and that I last saw h[illegible] alive on Oct 19 1946.

Immediate cause of death Coronary thrombosis. — Duration 3 days

Due to Arteriosclerotic heart disease — 15 yrs.

Due to —

Other Conditions Arteriosclerosis, general. — 15 yrs

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: None.

of autopsy: not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Buchanan M. D.
Address Church Home + Hosp. Date signed 10/19/46

VS 180

G44730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G44730 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Radnor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss LaVerda Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29th 1905

8. AGE: Years	Months	Days	If less than one day
41	5	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Secretarial Work

11. Industry or business U. S. Int. Revenue Dept

FATHER 12. Name John L. Thomas

13. Birthplace Richmond, Va.

MOTHER 14. Maiden Name Sarah E. Anderson

15. Birthplace Md.

16 (a) Informant Melvina Ruppert Chevy Chase

(b) Address 315 Lynn Drive Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location " Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) Washington Williams, M.D.

(Filed) (Signature of registrar) Registrar

20 1946

VS 11c

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1946 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1946 to 10/18 1946. and that I last saw h alive on 10/18 1946.

Immediate cause of death Septicemia

	Duration
Due to Peritonitis	12 days
Due to Tubo-ovarian abscess	2 Wks
Other Conditions Uterine fibroid	

(Include pregnancy within 3 months of death)

Date of operation Sept 27 1946

Major findings of operation: Uterine fibroid. Tubo-ovarian abscess.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert Harrison M. D.

Address 1 Wyoming Ave. Date signed

Dr. 12-6-44 F45440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44731 Registered No. 336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 Sharwood Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 6yr. 2M. 21D.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 1903 Sherwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1217 St. Paul Street~~
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry T. Litz, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1942

8. AGE: Years	Months	Days	If less than one day
4	7	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Henry T. Litz, Sr.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Delsby Hall
15. Birthplace Baltimore

16 (a) Informant William Cook, Inc.
(b) Address 1217 St. Paul Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Holy Redeemer Cemetery

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Oct. 19, 46 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1946, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1946 to 10/19 1946, and that I last saw h/her alive on 10/19 1946

Immediate cause of death	Duration
Influenzal Meningitis	3 days
Due to	
Due to	
Other Conditions Malnutrition	years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blume M. D.
Address 1266 E. Preston Date signed 10/19/46

VS 150

Huntington for William

G44732

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131C

G44732
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3511 Third Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3511 Third St Balto.25
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Rhoda Foote

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Homer M Foote
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 -1898

8. AGE: Years 48 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jesse Haxton
13. Birthplace Penn

MOTHER
14. Maiden Name Mamie Southam
15. Birthplace Penn.

16 (a) Informant Mr Homer M Foote
(b) Address 3511 Third St -25-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46. (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St -25-

19 (a) 10 20 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION .45

20. DATE OF DEATH October 19th 1946 at 6.P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1946. to Oct 19 1946.
and that I last saw h alive on Oct 18 1946.

Immediate cause of death: Bilateral Kidney Disease — Duration 1-yr

Due to

Due to

Other Conditions High Blood Pressure 1-yr
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature A. L. Hearn (M.D.)
Address 390 Eastern Ave Date signed Oct 20 46

VS 189

G14733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G14733
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 North Duncan
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES NOCAR

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Theresa Nocar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1880

8. AGE: Years 65 | Months 68 | Days 11 | If less than one day hr. min. | 17

9. Birthplace Bohemia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name John Nocar

13. Birthplace Bohemia

14. Maiden Name Antonia Hondeb

15. Birthplace Bohemia

16 (a) Informant Theresa Nocar

(b) Address 703 N. Duncan Street

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross G.G.B.C.

Location Cemetery Rd Bel Air

18 (a) Funeral director Hugh Brockson Son

(b) Address 900 N. Chester St

19 (a) 10 20 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/46 19 , at 10 p M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John L. Wars, M.D.
Medical Examiner.

Date signed 10/17/46

VS 181

G44734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 242 S.Eden St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - V

(e) Length of stay in Baltimore (yrs., mos., or days) 13 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 S. Eden (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Amoriello

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~Xxxx~~ Pasquale Amoriello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1887

8. AGE: Years	Months	Days	If less than one day
59	6	3	hr. min.

9. Birthplace Luzzano Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Carlo Massaro
13. Birthplace Italy

MOTHER
14. Maiden Name Porzia Tirina
15. Birthplace Italy

16 (a) Informant Pasquale Amoriello (Husband)
(b) Address 242 S.Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct.22/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.Balto.Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N.Morley St.

OCT 20 1946 (b) Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-46 19 , at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22-46 19 , to 10-17-46 19 , and that I last saw h[illegible] alive on 10-17-46 19 .

Immediate cause of death: Hypostatic pneumonia

Due to Hypostatic pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.
M. D.
Address 242 S. Eden St. Date signed 10-18-46

G44735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G44735 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 540 N. Luzerne a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 540 N. Luzerne a (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hessie A. Kelly (McKinney)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward F. Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10 1873

8. AGE: Years 73 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

BOTHER'S PARENTS

12. Name Whitmire

13. Birthplace Carroll Co Md.

14. Maiden Name Don't Know

15. Birthplace

16 (a) Informant E. F. Kelly

(b) Address 540 N. Luzerne Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)

(c) Cemetery or crematory Mt. National Location Frederick Md.

18 (a) Funeral director John A. McKean

(b) Address 300 E. Balto St

19 (a) Date received (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1946 to 10-19-1946, and that I last saw h[illegible] alive on 10-19- 1946.

Immediate cause of death	Duration
Uremia	2 weeks
Due to Hypertension	3 years
Due to Cardio-vascular-renal disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. B. Wade M. D.

Address 448 N. Luzerne Ave Date signed 10-19-46

VS 150

G44736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

G44736 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Ellerslie ave
(c) Hospital or institution St Elizabeth's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Ellerslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Leo Helen Walsh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 30 1870
8. AGE: Years 76 Months 2 Days 17 If less than one day hr. min.
9. Birthplace Owego N. Y (Town, county, and state)
10. Usual Occupation Nun
11. Industry or business

FATHER
12. Name John Walsh
13. Birthplace Cork Ireland

MOTHER
14. Maiden Name Johanna Collins
15. Birthplace Cork Ireland

16 (a) Informant Rev Mother Imelda
(b) Address St Elizabeths Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 1946 (month) (day) (year)
(c) Cemetery or crematory St Elizabeths Home
Location Balto Md

18 (a) Funeral director Henry W Jenkins & Son
(b) Address McCulloh & Orchard Sts

19 (a) (b) (Date received by registrar)

Oct 20 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1946, at 7 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946 to Oct 17 1946, and that I last saw h alive on Oct 17 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 4 hr
Due to: Hypertension and Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature J W Thalheimer M. D.
Address 1129 St Paul St Date signed 10/19/46

401704 G44737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45B

G44737 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Rhodell
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lunda Foley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1-74

8. AGE: Years	Months	Days	If less than one day
72	8	19	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Abram Foley
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Jane Reed
15. Birthplace W. Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 21-46 (month) (day) (year)
(c) Cemetery or crematory SUNSET Cemt.
Location BECKLEY W. VA.
18 (a) Funeral director John D Mitchell
(b) Address 1900 Eutaw Pl.
19 (a) Filed by registrar Huntington Nov 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1946, at 2 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13- 1946 to 10-20-1946, and that I last saw h[illegible] alive on 10-20- 1946.

Immediate cause of death Pneumonia (a)

Duration

Due to

Due to

Other Conditions Carcinoma tongue

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Sanford M. D.
Address Huntington W. Va.

VS 150

G44738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G44738 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 S. Curley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S. Curley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Tenner.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John M. Tenner (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 26, 1875

8. AGE: Years	Months	Days	If less than one day
71	4	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

INFORMANT / PATIENT
12. Name Shaw
13. Birthplace Unknown
14. Maiden Name Mary A. Canton
15. Birthplace Baltimore
16 (a) Informant Mrs. John M. Tenner
(b) Address 100 S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22 46 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Eastern ave
18 (a) Funeral director S. Walter May
(b) Address 649 N. Bond St.
19 (a) Filed Oct 19 1946 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1946 at 1 05 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Oct 18 1946 and that I last saw h[illegible] alive on Oct 17 1946.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	12-2-45
Generalized Arthritis	12-2-45
Due to Chr Hypertensive Heart	12-2-45
Emphysema	6-12-46
Due to Myocardial Infarct	10-2-46
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. A. Schimunek M. D.
Address 842 S. Conkling Date signed 10-19-46

VS 8

X

Auto Service

1733

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 94a

G44739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Newburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. Johnson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Weiss.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years 64 Months Days If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

PARENTS
12. Name
13. Birthplace

BROTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 21 1946 (month) (day) (year)
(c) Cemetery or crematory B'rai Sayal
Location Newburg, N.Y.

18 (a) Funeral director Wm. J. Tichenor & Sons
(b) Address North & Pa. Aves.

OCT 21 1946 Washington, D.C. Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1946 at 4:18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1946 to Oct 20 1946 and that I last saw h living on Oct 20 1946

Immediate cause of death Acute purulent Bronchitis causing Asphyxia — Duration

Due to Chronic pulmonary fibrosis

Due to Generalized arteriosclerosis

Due to Pulmonary emphysema

Other Conditions Coronary arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. M. Knight M. D.
Address Johns Hopkins Hosp. Date signed 10/20/46

VS 150

4740 390217 P.R.R. BALTIMORE CITY HEALTH DEPARTMENT X G44710

CERTIFICATE OF DEATH 47a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Gallatin (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lenzi
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elvira
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Lenzi
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Labastrida
15. Birthplace Italy

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Monongahela
Location Penna.

18 (a) Funeral director Wm. J. Tichenor & Sons
(b) Address North & Pk. Aves.

OCT 21 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1946 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1946 to Oct. 20 1946 and that I last saw him alive on Oct. 20 1946

Immediate cause of death Respiratory failure | Duration

Due to Intracranial Hemorrhage & Subdural Hemorrhage

Due to Laennec's Cirrhosis of Liver

Other Conditions Carcinoma of Larynx.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature A.M. Knight M.D.
Address J. H. Hosp Date signed 10/20/46

VS 150

4741 397790

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH √106 B

Registered No. G44741

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town TAMPA, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Albany Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christobal De La Torre

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-19-94

8. AGE: Years	Months	Days	If less than one day
52	3	1	hr. min.

9. Birthplace Cuba. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Pilar De La Torre.,
13. Birthplace Cuba.

MOTHER
14. Maiden Name Aballa Manuela.,
15. Birthplace Cuba.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Tampa Florida,
Location
18 (a) Funeral director John O Mitchell & Son,
(b) Address 1900 Nstan Place C.
19 (d) Date received by Registrar 11 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1946 at 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1946. to 10-20 1946. and that I last saw him alive on 10-20-1946.

Immediate cause of death Pulmonary Edema - Aortic Pneumonia ? Duration 48 hrs

Due to Bronchiectasis, Rt. Lung

Pneumonectomy, Rt.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 10/18/46

Major findings of operation: Bronchiectasis Adherent Rt lung to entire chest wall

Date of autopsy

PHYSICIAN
Underline the causes to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo Durward, M.D.
Address Date signed 10/20/46

VS 150

X

44742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√X 61

G44742
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace M. Barr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24-1884

8. AGE: Years	Months	Days	If less than one day
62	1	26	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER | FATHER

12. Name James Franklin

13. Birthplace Md.

14. Maiden Name Kate Farmer

15. Birthplace Md.

16 (a) Informant Charles Barr

(b) Address New Windsor Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22-1946 (month) (day) (year)

(c) Cemetery or crematory Ebenezer Cemetery

Location Westfield Md

18 (a) Funeral director D. D. Stonesifer Son

(b) Address New Windsor Md

Date received by local registrar (b) Huntington Williamsport Md

OCT 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1946 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1946 to 10-20 1946 and that I last saw h[illegible] alive on 10-19 1946.

Immediate cause of death: Respiratory failure
Cardiac dilitation

Due to Hypertension C.V. Disease, Diabetes mellitus

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Shallenberger M.D.
M. D.

Address Date signed

X

1743 BC. 9-07814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44743 Registered No.

1610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland Gen Hosp
(c) Hospital or institution: Madison & Linden Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Lemmon St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Gae Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6. (a) Single, married, widowed, or divorced Infant

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/46

8. AGE: Years | Months | Days | If less than one day hr. 5 min.

9. Birthplace Md. Gen. Hosp. Balto
(Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER — 12. Name George Gae
13. Birthplace Pland

MOTHER — 14. Maiden Name Rose Mraz
15. Birthplace Baltimore

16 (a) Informant George Gae
(b) Address 1435 Lemmon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto., Md.

18 (a) Funeral director Chas. F. Dill
(b) Address 1321 E. Fort Ave.

OCT 21 1946 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1946, at 5.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1946, to Oct 19 1946, and that I last saw him alive on Oct 19 1946.

Immediate cause of death: Asphyxia Neonatorum

	Duration
Due to: Prolonged and complicated labor from Faulty position.	
Due to:	
Other Conditions: Foreign Examination of Labor. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Faden Monta M. D.
Address 1116 Cathedral St Date signed 10-21-46

VS 150

1714 TN. 105318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G24714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Bradley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Enice Blake Ennie Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
? 43			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Wm Jones
13. Birthplace ?

MOTHER
14. Maiden Name ? Maggie —
15. Birthplace ??

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 142 Wotice St
(c) Oct 21 1945 (Date rec'd by registrar) Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19th 1946 19 , at 8.19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16th 1946 to Oct 19 1946, and that I last saw her alive on Oct 19 19 46.

Immediate cause of death Respiratory Failure. — Duration ?

Due to Cardiovascular Accident

Due to

Other Conditions Possible nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ennie Beadon
Address Baltimore Md. Date signed Oct 24 46.

VS 150

4715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Eden St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louise M. Murphy

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Jerome

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 6 1874

8. AGE: Years 72 | Months 4 | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business:

FATHER — 12. Name: George Schelhase
13. Birthplace: Germany

MOTHER — 14. Maiden Name: Christina Zion
15. Birthplace: Germany

16 (a) Informant: Minnie Bichass (sister)
(b) Address: 345 Scott St 31

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/21/46 (month) (day) (year)
(c) Cemetery or crematory: Catonsville Greenmount
Location: Greenmount to North Ave.

18 (a) Funeral director: M. W. E. Dippel's Sons
(b) Address: Lombard & Ann Sts.

OCT 21 1946 (b) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1946 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to Oct 18 1946 and that I last saw her alive on Oct 18 1946

Immediate cause of death: General Arteriosclerosis / Chronic myocarditis — Duration: 10 yrs / 10 yrs

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Milton L. Solomon

Address: 129 S. Paca Date signed: 10/19/46

4746 — 383066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44746 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Div

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-09

8. AGE: Years 37 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Alfred Brumwell
13. Birthplace Md

MOTHER — 14. Maiden Name Minnie Dewey
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Baltimore Co. Md

18 (a) Funeral director Wilson & Son Fun. Dir.
(b) Address 1219 Lt. Pratt St.

19 Date received OCT 21 1946 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1946 at 6:55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18- 1946 to 10-20-1946 and that I last saw her alive on 10-20-1946

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs.
Due to Hypertension	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip J. Wagley M. D.
Address Johns Hopkins Hosp. Date signed 10-20-46

VS 150

747. BC# D55213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G44747
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 Mangold St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 Mangold St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Catherine D. Ringrose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1946

8. AGE: Years	Months	Days	If less than one day
	2	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Melvin Ringrose
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Daisy Newsome
15. Birthplace North Carolina

16 (a) Informant Melvin Ringrose
(b) Address 803 Mangold St.

17 (a) Burial (b) Date thereof Oct. 22/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 21 1946 (b) Livingston Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1946 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1946 to 10/20 1946, and that I last saw him alive on 10/20 1946.

Immediate cause of death: Bronchopneumonia — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 30 Williams Date signed 10/20/46

VS 150

1748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34748 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2120 Park ave
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gretta Weiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Dared

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Caesar
15. Birthplace Russia

16 (a) Informant Aaron Fox
(b) Address 2120 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Metzger

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Baltimore St

19 (a) 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1946, at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to 10/21/1946 and that I last saw her alive on 10/20 1946

Immediate cause of death: Apoplexy

Duration: 5 days

Due to generalized arterio-sclerosis

Due to 2040

Other Conditions Coronary Thrombosis July 19 46

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack Cohen

Address 1804 Eutaw Place Date signed 10/21/46 M. D.

VS 180

X

4749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1121

G41749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3941 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted], BENJAMIN BRILL

3 (b) If veteran, name war

3 (c) Social Security Account No. 364-09-9079

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mollye

6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Deud
15. Birthplace Russia

16 (a) Informant Mollye Brill
(b) Address 3941 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Baltimore St

19 (a) (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1946 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1946, to 10-20 1946 and that I last saw h[illegible] alive on 10-20 1946

Immediate cause of death	Duration
CEREBRAL ANOXIA	
Due to SURGICAL SHOCK	
SECONDARY ANEMIA	
Due to RUPTURED APPENDIX	
Other Conditions PITUITARY TUMOR?	

(Include pregnancy within 3 months of death)
Date of operation 10-19-46
Major findings of operation: Ruptured Appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Sinai Hospital Date signed 10-25-46

VS 150

750

502878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 94750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Bronx (If outside city or town limits, write RURAL and give town)
(d) Street No. 1987 Davidson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Pitsnick (Pitnick)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Rose P.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 7-15-82

8. AGE: Years 64 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Singer Sewing machine Op.

11. Industry or business

FATHER: 12. Name Sydney Pitsnick
13. Birthplace Russia

MOTHER: 14. Maiden Name Sarah Pliadmonsky
15. Birthplace Russia

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory Location New York City N.Y.

18 (a) Funeral director Jos. Lewis Sons
(b) Address [illegible]

19 (a) OCT 21 1946 (Date rec'd by registrar) Huntington Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-21 1946 at 2.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-17 1946 to Oct-21 1946 and that I last saw him alive on Oct. 21 1946.

Immediate cause of death Infarction of anterior myocardium — Duration 4 days

Due to arteriosclerotic coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Austen

Address Johns Hopkins Hosp. Date signed 10-24-46

VS 150

1751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1576

Registered No. C 14751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Rustletown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN THOMAS JONES

(b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14-46

8. AGE: Years | Months | Days 6 5 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co (Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Wm. M Jones

13. Birthplace Virginia

14. Maiden Name Gladys Pritt

15. Birthplace West Virginia

16 (a) Informant Wm M Jones

(b) Address Rustletown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21-46 (month) (day) (year)

(c) Cemetery or crematory Mt Pleasant

Location Carroll Co

18 (a) Funeral director J. F. Elsie Sons

(b) Address Rustletown Md.

19 (a) Oct 21 1946 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1946 3.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Congenital malformation of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 10-21-46

VS 191

752

497569.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G44752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 N. Bullough St (If rural give location)
(e) Citizen of foreign country? Mc Cotlch (Yes or No) If yes, name country

3 (a) FULL NAME Gladys Wake.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Cook-
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 12-25-12.

8. AGE: Years	Months	Days	If less than one day
33.	9	21	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business

FATHER
12. Name Douglass Gwaltis
13. Birthplace md

MOTHER
14. Maiden Name Louise Coates
15. Birthplace Va

16 (a) Informant Reuon.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lee H. Holland
(b) Address 1691 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct-16 1946. at 1130 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1946. to Oct-16 1946. and that I last saw her alive on Oct-16 1946.

Immediate cause of death: Circulatory failure — Duration

Due to generalized Carcinoma

Due to Carcinoma of the Cervix League at Mthms IV

Other Conditions Vesico vaginal fistula Recto vaginal fistula
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Felix Rattledge M. D.
Address Johns Hopkins Date signed 10/19/46

VS 150

14753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G14753
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Foster Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD KELLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1865.

8. AGE: Years 81 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business House-Painter.

SURVIVING PARENT

12. Name Edward Keller

13. Birthplace Germany.

14. Maiden Name Dorothea Mader

15. Birthplace Germany.

16 (a) Informant Mary Neilson (Sister)
(b) Address 3021 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-46. (month) (day) (year)
(c) Cemetery or crematory St. Mathew's Luth
Location 6104 O'Donnell St.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

OCT 21 1946
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/46 19 3:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Davis M.D.
Medical Examiner.
Date signed 10/20/46

VS 151

X

4754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G44754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5513 Gwynn Oak Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5513 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Josephine Holderby

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? Abt. 1872

8. AGE: Years	Months	Days	If less than one day
About 74	-	-	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph B. Holderby
13. Birthplace North Carolina

MOTHER
14. Maiden Name Jessie Thomson
15. Birthplace Scotland

16 (a) Informant Julia H. Young
(b) Address 5513 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Rock Creek Cemetery
Location Washington, D. C.

18 (a) Funeral director Willis Lamond
(b) Address 4510 Liberty Heights Ave.

19 OCT 21 1946 (Date received by registrar) (b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1946, at 11.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/46 19 and that I last saw her alive on 10/14/1946 19

Immediate cause of death Coronary Occlusion — Duration Last few minutes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Harper

Address 5201 Gwynn Oak Ave. Date 10/20/46

X

4755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G44755 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edmund Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha S. Evans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	married

6 (b) Name of husband or wife George Evans
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 26 1877

8. AGE: Years	Months	Days	If less than one day
69	8	26	hr. min.

9. Birthplace Annapolis Md
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name Mathew Brohm
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Rodeyer
15. Birthplace Germany

16 (a) Informant George Evans
(b) Address Edgewood Forest. Md

17 (a) Buried (b) Date thereof Oct 22 1946
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory St. Anns
Location Annapolis Md

18 (a) Funeral director Phillip Lamoreau
(b) Address 410 Liberty Heights Ave

OCT 21 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1946, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19/1946 to Oct 19, 1946, and that I last saw h.... alive on 10/19/1946.

Immediate cause of death: Respiratory Failure — Duration
Due to: Cerebral vascular Accident
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. Dorea Clark, M. D.
Address University Hospital Signed 10-21-46

VS 150

756 BALTIMORE CITY HEALTH DEPARTMENT G44756

HB # 101616 CERTIFICATE OF DEATH 186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 19
(e) Length of stay in Baltimore (yrs., mos., or days) 62 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Gwynoak Ave. Zone #7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Jennings Lizzie F. Jennings

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1866

8. AGE: Years	Months	Days	If less than one day
80	8	0	hr. min.

9. Birthplace Virginia, Fredericksburg
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER: 12. Name Alexander Jennings (d)
13. Birthplace Va.

MOTHER: 14. Maiden Name Rebecca Layton (d)
15. Birthplace Va.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Eastern Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Gilbert Lamoreaux
(b) Address 4510 Liberty Heights Ave.

OCT 21 1946 (Date rec'd by Registrar) Thornton for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1946 at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1946 to Oct. 18 1946 and that I last saw h er alive on Oct. 18 1946

Immediate cause of death Cardio-respiratory failure. — Duration

Due to Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions Intertrochanteric fracture of femur

(Include pregnancy within 3 months of death)

Date of operation 6/2/46 7/11/46

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5/28/46 at 9 a M
(c) Where did injury occur? 3620 Gwynoak Ave
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? —
(Specify type of place)
(e) Means of injury fall to floor

23. Signature [illegible]
Address Balto. City Hospitals Date signed 10/18/46 M D

VS 150 To Be Approved By The Medical Examiner George G. Merrill M.D.

1757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3245 Normount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3245 Normount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. BUCHEIMER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife S. Catherine Bucheimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	14	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Mathias Bucheimer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name -
15. Birthplace

16 (a) Informant Mrs. Evelyn Yost
(b) Address 3243 Normount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 21 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1946 at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 17, 1946 and that I last saw h[illegible] alive on Oct. 17 1946.

Immediate cause of death Chr. Myocarditis — Duration

Due to

Due to

Other Conditions Hypostatic Pneumonia.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Shannon M.D.
M. D.
Address 720 Medical Arts Bldg Date signed 10/22/46

VS 150

X

1758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44758 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3015 Shannon Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Shannon Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Theresa Houseman

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Edward Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1873

8. AGE: Years	Months	Days	If less than one day
73	6	16	hr. min.

9. Birthplace Massachusetts (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph T. Cooney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Scally
15. Birthplace Ireland

16 (a) Informant Mrs. Edna M. Arnold
(b) Address 3015 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Penna. Aves.

19 (a) 11-1-1946 (Date rec'd by Registrar) (b) Hunter Jr. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h, alive on 19.

Immediate cause of death — Duration

(a) Coronary thrombosis

Due to (b) Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Stevens M. D.
Address 3400 Eadwan Date signed 10/21/46

VS 150

759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44759 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 330 E. University Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 E. University Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN M. WELDON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida E. Weldon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1865

8. AGE: Years	Months	Days	If less than one day
80	10	17 19	hr. min.

9. Birthplace New Jersey
(Town, county, and state)
10. Usual Occupation Building Manager
11. Industry or business Wm. Martien

FATHER
12. Name John M. Weldon
13. Birthplace N. J.

MOTHER
14. Maiden Name Ellen Young
15. Birthplace N. J.

16 (a) Informant Mrs. Ida E. Weldon
(b) Address 330 E. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Elkridge, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address North & Penna Aves, Baltimore

OCT 21 1946 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1946, at 8 P M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Oct 18 1946, and that I last saw him alive on Oct 18 1946.

Immediate cause of death	Duration
Myocarditis Arteriosclerosis	
Due to Pulmonary Congestion	
Due to Or Hypostatic Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jos E Whitehill M. D.
Address 330 E Univ Pky Date signed 10/19/46

VS 150

X

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

G44760

CERTIFICATE OF DEATH 94a

Reg. Dist. No.

CE OF DEATH:
1221 S. CHARLES ST.
BALTIMORE MD.
(If outside city or town limits, write RURAL and give nearest town)
above place of death?
stitution, or street address where death occurred:
hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County
City or town BALTIMORE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1221 S. CHARLES ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

ULL NAME ALVINA SCHULTE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

e of husband or wife HENRY W. SCHULTE
6.(c) If alive, give age 68 years
te of d (mo., day, yr.) JANUARY 1860

Years	Months	Days	If less than one day
86	9		hrs. min.

ce CINCINNATI, OHIO
(Town, county, and state)
occupation
ry or business
ame HENRY SCHULTE
birthplace GERMANY
Maiden name -UNK-
birthplace -UNK-
ant HENRY W. SCHULTE
ss 1221 S. CHARLES ST.
BURIAL Date thereof 10/22/46
l, cremation, or removal. Which?) (month) (day) (year)
ry or crematory WOODLAWN
WOODLAWN, MD.
al director JOHN F. DENNY, INC.
715 LIGHT ST.
T 21 1946 Huntington Williams, M.D.
e rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/46 at 1230 P.M.

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from Oct 15, 46 to 10/19/46
and that I last saw h alive on 10/19/46

	DURATION
Immediate cause of death Coronary occlusion	1/2 hour
Due to Arteriosclerosis	
Due to Senility	
Other conditions Chronic Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Isaac Adler M.D.
M. D. or other
Address 1221 S Charles St Date signed 10/19/46

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 46E

G44761
Reg. Dist. No.

CE OF DEATH: 35 E. HENRIETTA ST.
BALTIMORE, MD.
(If outside city or town limits, write RURAL and give nearest town)
above place of death?
estitution, or street address where death occurred. 43
hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County
City or town BALTIMORE,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 35E HENRIETTA ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

ULL NAME ANNE ELIZABETH REIGN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

e of husband or wife SAMUEL BOWIE REIGN
6.(c) If alive, give age years
e of d (mo., day, yr.) OCT. 10, 1869

Years	Months	Days	If less than one day
77	-	10	hrs. min.

BALTIMORE, MARYLAND
(Town, county, and State)
occupation
y or business SCHLIPPER
UNKNOWN
UNKNOWN
UNKNOWN
MR FREDERICK REIGN
35 E. HENRIETTA ST.
BURIAL Date thereof 10 22 46
, cremation, or removal. Which?) (month) (day) (year)
y or crematory MT. OLIVET
FREDERICK AVE
al director JOHN F. DENNY, INC
715 LIGHT ST.
21 1946 Huntington Williams, M.D.
ved by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1946, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 13, 1944 to 10/20/ 1946.
and that I last saw her alive on Oct. 19, 1946

Immediate cause of death Carcinoma of lower bowel and rectum. DURATION 2 yrs. 7 mos. 7 days

Due to

Due to

Other conditions Hypertensive cardio vascular disease. ?
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry Deibel, M.D.
M. D. or other
Address 1226 Hanover St. Date signed 10/21/46

762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G44762

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 Pitcher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Pitcher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY GUSTUS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Louis Gustus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1864

8. AGE: Years 82 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nathaniel Quill
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Md.

16 (a) Informant Caroline Brooks
(b) Address 4234 Evans Chapel Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1946 (mo.) (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

OCT 21 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1946, at 9 M M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1946, to Oct 19 1946, and that I last saw h[illegible] alive on Oct 19 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2

Due to Hypertension — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Welcome M. D.
Address 1131 Harlem Ave Baltimore
10/19/46

4763

CHK-105552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

G44763 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Arlington Avenue-Z-21 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip Erwin Howell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2-1921

8. AGE: Years	Months	Days	If less than one day
25	3	17	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wallace Howell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Anna Boddie
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 OCT 21 1946 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1946, at 4:07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1946 to Oct. 19 1946, and that I last saw him alive on Oct. 19 1946.

Immediate cause of death: Acute Glomerular Nephritis — Duration: 2 wks

Due to

Due to

Other Conditions: Acute Cardiac Failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund B. Beadles

Address Balto City Hosp Date signed 10-21-46

VS 150

1764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44764 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Holbrook Street
(c) Hospital or institution:

9 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Wernig

3 (b) If veteran, name war	3 (c) Social Security Account No.		
None	None		
4. Sex: Male	5. Color or race: White	6 (a) Single, married, widowed, or divorced: Married	

6 (b) Name of husband or wife Josephine A. Hahn
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1871

8. AGE: Years	Months	Days	If less than one day
74	11	15	######## min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Employee

FATHER
12. Name Charles F. Wernig
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Angelina
15. Birthplace Germany

16 (a) Informant Mrs. Josephine A. Wernig
(b) Address 1722 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 21 1946 (b) Date rec'd by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18th., 1946 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Oct 18 1946. and that I last saw him alive on Oct 17 1946.

Immediate cause of death — Duration

Due to Coronary Thrombosis — 6 Weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny
Address 2200 E Madison St Date signed 10/19/46 M. D.

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G44765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 79
(e) Length of stay in Baltimore (yrs., mos., or days) 79

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 HOLBROOK ST. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HIRAM VINCENT DARDEN

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-03-1424

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Evelyn Tarlton

6 (c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Sept 9th, 1913

8. AGE: Years 33 | Months 1 | Days 11 | If less than one day: ~~hours~~ ~~min.~~

9. Birthplace: Norfork, Virginia (Town, county, and state)

10. Usual Occupation: NOT ANY (Unemployed)

11. Industry or business: Welder, Ship Yard

FATHER
12. Name: Hiram Lester Darden
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Florence Johnson
15. Birthplace: Virginia

16 (a) Informant: Mrs. Florence Darden
(b) Address: 1432 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: E. North Avenue, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

OCT 21 1946 (Date received by Registrar) (By) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/46 19 ~~at~~ 1265 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 19 46 to Oct 20 19 46 and that I last saw him alive on 10/20 19 46.

Immediate cause of death: CARDIO RESPIRATORY FAILURE
Due to: CARCINOMA LUNG
Due to: CARCINOMA ADRENAL GLANDS
Other Conditions:

Duration

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: CA. LUNGS; ADEN.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John B WELLS
Address: ST JOSEPH, HOSP Date signed: 10-20-46

VS 150

4766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G44766 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 S. Gilmor st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Albright

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Louis Albright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 1870

8. AGE: Years	Months	Days	If less than one day
76	2	22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Tiereck
13. Birthplace Germany.

MOTHER
14. Maiden Name Louise Brady
15. Birthplace Germany.

16 (a) Informant Mr Vernon Albright
(b) Address 113 S Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo L Boyer Jr
(b) Address 1512 Hollins St

19 (a) 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1946, at 11:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1944 to Oct 19 1946, and that I last saw her alive on Oct 19 1946.

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular Disease	?
Due to	
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl H. Kosking M. D.
Address 1316 N. Loudon St. Date signed 10-21-46

VS 150

X

G44767 ✓ G44767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1331 N. Caroline St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/1906

8. AGE: Years	Months	Days	If less than one day
39	11	3	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Fred. Debere
13. Birthplace West Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Catherine Hill
(b) Address 2552 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) 21 1946 (Date rec'd by registrar) (b) Burlington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1946, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1943 to Oct 18 1946 and that I last saw h[illegible] alive on Oct 12 1946

Immediate cause of death: Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2-20-43

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. K. Adams M. D.
Address 1222 N. Caroline Date signed 10-24-46

VS 130

X

G44768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G44768 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. b
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

(a) FULL NAME Albert S. Green

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1930

8. AGE: Years 16 | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

12. Name Wesley Johnson
13. Birthplace Baltimore, Md.
14. Maiden Name Charlotte Smallwood
15. Birthplace Baltimore, Md.

16 (a) Informant Charlotte Johnson
(b) Address 469 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore, Md.

18 (a) Funeral director Ida Bailey
(b) Address 1421 E. Jefferson st.

19 (a) OCT 21 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1946 at 9 20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Gunshot wound involving the brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-18-46 at 8 40 P. M.
(b) Where did injury occur? 1900 blk. of Jefferson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms —

23. Signature Howard J. Mueseig M.D.
Medical Examiner.
Date signed 10-19-46

VS 191

8

X

Dr Wolford G44769
1331 - E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 D

G44769
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Edmondson Highway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo T. Woolford
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mollie L. Woolford
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Nov 20-1870

8. AGE: Years	Months	Days	If less than one day
75 76	11	—	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Joseph Woolford
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Ball
15. Birthplace Maryland

16 (a) Informant Mollie L. Woolford
(b) Address 511 North Decker Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 23 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.
18 (a) Funeral director John C. Miller Sons
(b) Address 2455 E. Oliver St
19 (a) 1946 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945 to Oct. 20 1946 and that I last saw him alive on Oct. 20 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel Wolfe M. D.
Address 1331 E. North Ave. Date signed 10-24-46

VS 180

G94770 ✓ G94770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56D

501936 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 S. Robinson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Battersby.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) 9-29-30

8. AGE: Years	Months	Days	If less than one day
16.	0	21	hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation school girl
11. Industry or business

FATHER
12. Name George Battersby
13. Birthplace md.

MOTHER
14. Maiden Name Catherine Busse
15. Birthplace md

16 (a) Informant Reynolds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road.

18 (a) Funeral director John F. Willy Inc.
(b) Address 2436 E. Oliver St.

19 (a) 10-24-1946 (Date filed by registrar) (b) Huntington Williams (Deputy)

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 20 1946 at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1946 to Oct. 20 1946 and that I last saw h[illegible] alive on Oct. 20 1946.

Immediate cause of death: Cerebral edema — Duration: 2 years

Due to Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 18, 1946

Major findings of operation: Tumor of Brain

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur M Laing M. D.
Address Johns Hopkins Hosp Date signed 10/24/46

VS 150

G44771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G44771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3456 Hickory Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3456 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Lewis M. Lohr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-07-7592

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Mollie Lohr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6-1878

8. AGE: Years 68 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Frederick Co. Maryland (Town, county, or state)

10. Usual Occupation Church Sexton

11. Industry or business

FATHER
12. Name John L. Lohr
13. Birthplace Maryland

MOTHER
14. Maiden Name Agnes E. Favorite
15. Birthplace Maryland

16 (a) Informant Miss Rosa M. Lohr
(b) Address 3456 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22-1946 (month) (day) (year)

(c) Cemetery or crematory St. Marys Romish
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1946 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Oct 19 1946 and that I last saw him alive on Oct 18 1946.

Immediate cause of death: Cardiac decompensation — Duration 1 mo.

Due to: Cardio-vascular-renal disease — 5 yrs.

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jean Devereux, M.D.
Address 846 W 36 St Date signed 10/31/46

VS 150

Huntington Williams, M.D.

X

G44772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G44772 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 W Bare St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 W Bare St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Murray

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1984

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Maried

6 (b) Name of husband or wife Annie Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16. 1878

8. AGE: Years	Months	Days	If less than one day
68 69	6	3	hr. min.

9. Birthplace Calvert County Maryland (Town, county, and state)
10. Usual Occupation Federal old age Luhrims
11. Industry or business Benefits.

MOTHER / FATHER
12. Name Unknown to me
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Annie Murray
(b) Address 619 West Bard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore County Md

18 (a) Funeral director Joseph A Sicily
(b) Address 66 West Bare Street

OCT 24 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1946, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946, to Oct 18 1946, and that I last saw him alive on Oct 18 1946

Immediate cause of death: Lobar Pneumonia (Left)

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Caldcomb M. D.
Address 113 Harlem Ave Date signed Oct 20/1946

VS 150

G44773 ✓ G44773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

836

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 Pamera St.
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Pamera St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie R. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Isaac Wallace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1859

8. AGE: Years	Months	Days	If less than one day
86	1	-	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Reardon.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Jane Arthur.
15. Birthplace Ireland.

16 (a) Informant Lula E Barrick.
(b) Address 806 Pamera St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Fairleigh Rd.

18 (a) Funeral director Hammett & Hammett
(b) Address 2610-12 Eastern Ave.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

OCT 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1946, at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1930 to Oct 19 1946, and that I last saw deceased alive on Oct 18 1946.

Immediate cause of death: cerebral thrombosis — Duration 3 days

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar H Wortham M.D.

Address 2706 St Paul St Date signed 10/21/46 M. D.

VS 150

X

G44774

BALTIMORE CITY HEALTH DEPARTMENT G44771 Registered No.

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2656 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2656 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE AMELIA PFISTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John J. Pfister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1866

8. AGE: Years	Months	Days	If less than one day
80	0	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Helwig Schanze
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Plitt
15. Birthplace Germany

16 (a) Informant Miss Margaret Pfister
(b) Address 2656 W. North Ave.

17 (a) Burial (b) Date thereof 10/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1946, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Oct 19 1946
and that I last saw h[illegible] alive on Oct 19 1946

Immediate cause of death	Duration
Coronary Thrombosis	10 days
Due to Cardio-Vascular Disease	2 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Greenmount Ave. Date signed 10/24/46

Registered Nov 1 1946 Huddleston Williams, M.D.

G44775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44775 Registered No. 136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Fleet Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOHN A. KAMOSA (KAMASINSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 16, 1900

8. AGE: Years	Months	Days	If less than one day
46	5	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Frank Kamasinski
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Kwiatkowska
15. Birthplace Popowie, Poland

16 (a) Informant Mrs. Barbara Kamosa
(b) Address 2003 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director M. F. Sankowski Sons
(b) Address 1804 Eastern Ave

19 (a) Date rec'd by registrar Huntington Williams OCT 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1946 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct. 18 1946, and that I last saw him alive on Oct 17 1946

Immediate cause of death	Duration
Coronary artery disease	1 day
Due to	
Due to	
Other Condition Pulmonary T.B. (Include pregnancy within 3 months of death)	at least 2 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Klemm
Address 2625 E. Monument Date signed 9/13/46 M. D.

94a

Fickus ✓

G44776 HEALTH DEPARTMENT—CITY OF BALTIMORE G44776

CERTIFICATE OF DEATH. 124 B

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 122 N Lemmon St.; 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J Fickus

(a) RESIDENCE. No. 122 N Lemmon St., Ward 16

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS 212-17-3423 MEDICAL CERTIFICATE OF DEATH

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie R. Koyter

DATE OF BIRTH (month, day, and year) 5/17/1876

AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	70	5	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mch.

(b) General nature of industry, business, or establishment in which employed (or employer) Sparrows Pt

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Schriver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie R. Fickus

(Address) 122 N Lemmon ave

15 Filed 21 1946 19 Huntington Williams, Jr. Registrar

18 DATE OF DEATH (month, day, and year) 10/16/46

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 46 19 to Oct 16 46 19

that I last saw h[illegible] alive on Oct 16 46

and that death occurred, on the date stated above, at 8 00 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis Disease

Hypertension

Cirrhosis of Liver

(Non Specific duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H K Mot Insley M. D.

19 (Address) 2936 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dist Lawn	10/22 19 46
20 UNDERTAKER	ADDRESS
Clarence F Hoffman	1039 Broadway

ZELICZYNSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44777 469 G44777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Joseph Hospital
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Bank Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stefan Zeliczynski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1880

8. AGE: Years	Months	Days	If less than one day
66	2	17	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Bethlehem Steel Corp

11. Industry or business

12. Name unknown

13. Birthplace Poland

14. Maiden Name unknown

15. Birthplace Poland

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 - 22 - 46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Balto City Dundalk

18 (a) Funeral director John J. Welsh

(b) Address 401 S. Chester St

(c) 10 21 1946 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1946, at 4:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1946 to 10/19 1946 and that I last saw him alive on 10/19 1946

Immediate cause of death: respiratory failure — Duration

Due to Ca of pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/16/46

Major findings of operation: Ca of pancreas & Ca of pancreas & Metastases

At autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John S. Simms

Address St. Joseph's Date signed 10/19/46 M. D.

VS 150

502 G44778 BCH ✓ G44778

BALTIMORE CITY HEALTH DEPARTMENT

B56545 CERTIFICATE OF DEATH 119a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Brook St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Baby Boy Fisher | Edward Li Fisher ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Boy

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-46

8. AGE: Years	Months	Days	If less than one day
	1	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Fisher
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence Wemmecke
15. Birthplace Maryland

16 (a) Informant Mother
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 408 S. Chester Street
(c) 10-21-1946 (Date rec'd by registrar) (d) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1946, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1946 to 10-20 1946, and that I last saw h. alive on 10-20 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Acute nutritional disturbance	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Dorman M.D.
Address Johns Hopkins Hosp. Date signed 10/20/46

VS 150

X

4779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. C34779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town, write RURAL, and name town)
(d) Street No. 3006 Fleetwood Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Wilson
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
(b) Name of husband or wife Marie E. Wilson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 28-1894
8. AGE: Years 51 | Months 10 | Days 22 | If less than one day hr. min.
9. Birthplace Salisbury N.C.
(Town, county and state)
10. Usual Occupation Mechanic
11. Industry or business H. T. Cowan Co.
12. Name ✓
13. Birthplace ✓
14. Maiden Name ✓
15. Birthplace ✓
16 (a) Informant Mrs. Marie Wilson
(b) Address 3006 Fleetwood Ave.
17 (a) Burial (b) Date thereof 10/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore
18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd.
10-21-1946 (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 20 Oct 1946 at 2:05 P M
21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH Coronary occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature William J. Kelbach M.D.
Medical Examiner
Date signed 21 Oct 46

VS 181

4780

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 160a

G44780

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Calvert
(a) State Md. (b) County Prince Frederick
(c) City or town Route Marlboro.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Rong.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male.	white.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-17-46

8. AGE: Years	Months	Days	If less than one day
		3 4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

PARENTS
12. Name Romond Rong
13. Birthplace Md.

MOTHER
14. Maiden Name Dorothy Gross
15. Birthplace Md.

16 (a) Informant Rondo.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory Mayanga
Location St. Mary's Co. Md.

18 (a) Funeral director Wilkes Funeral Home
(b) Address 2001 Orleans St.

OCT 21 1946 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1946; at 1.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1946, to Oct. 21 1946 and that I last saw him alive on Oct. 21 1946.

Immediate cause of death Respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to Erythroblastosis foetalis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Dorsmond M. D.
Address Johns Hopkins Hosp. Date signed 10/21/46

VS 150

X

G44781 BALTIMORE CITY HEALTH DEPARTMENT ✓ G44781 Registered No.

CERTIFICATE OF DEATH 13 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 Brant St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto. md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Brant St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Frank Winston

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-5269

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Golder Winston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 16. 1890

8. AGE: Years 56 Months 5 Days 4 3 If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Elias Winston
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Mrs Golder Winston
(b) Address 2805 Remington ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/41 (month) (day) (year)
(c) Cemetery or crematory mt. calvary
Location Anne arundel co. md.

18 (a) Funeral director William J. Chatmon Jr.
(b) Address 1701 ME Culloh St.

19 (a) Huntington Williams (Signature of registrar)
(b) Date received 21 1941 (By registrar)

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-41 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4-19 41 to 10-19-41 19 , and that I last saw h alive on 10-18-19 41

Immediate cause of death Chr Nephritis — Duration 1½?

Due to — Duration 1

Due to — Duration

Other Conditions Mild Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maria Olsen M. D.
Address 312 E 23rd Date signed 10-19-41

X

4782

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1278

Registered No. G44782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Spencer (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 4th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Frederick Sigman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1877

8. AGE: Years	Months	Days	If less than one day
68	10	19	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Roentgenologist
11. Industry or business

MOTHER / FATHER
12. Name R. S. Sigman
13. Birthplace Georgia
14. Maiden Name Mary Cushon
15. Birthplace Georgia

16 (a) Informant Mr. Frederick Sigman
(b) Address Alexandria Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory
Location Salisbury N. C.

18 (a) Funeral director Wm. J. Tuckey & Sons
(b) Address 1 E. Preston ave, Baltimore, Md.

OCT 22 1946 Huntington Williams, Md.
(Date rec'd by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Oct 1946, at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8-1946 to 10-21 1946, and that I last saw him alive on 10-21 1946.

Immediate cause of death	Duration
Hepato-Renal Syndrome.	
Due to Cholecystitis Purulent & Cholelithiasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10. 14 46
Major findings of operation: Perforated Gall Bladder, Gallstones
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Rosch
Address University Hosp. Redwood & Greene St. Date signed 10/21/46 M. D.

VS 150

4783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 E Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 E Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M Leight

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Nicholas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1870

8. AGE: Years	Months	Days	If less than one day
76	4	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Prichard
13. Birthplace Wales

MOTHER
14. Maiden Name Elizabeth Dwyer
15. Birthplace Norfolk Va

16 (a) Informant Carl Frederick Jr
(b) Address 329 E Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Gilbert Colton Inc
(b) Address 1519 St Paul St

OCT 22 1946 (Date filed by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1946 to 10-19 1946 and that I last saw her alive on 10-19 1946

Immediate cause of death
Arteriosclerotic Cardio-Vascular Disease

Duration
2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. D. Flynn, M. D.
Address 11 E Chase St Date signed 10-21-46

VS 150

P. D. Flynn X

44784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G44784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 Olive Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Olive Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME George Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/00

8. AGE: Years	Months	Days	If less than one day
46	7	16	hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

FATHER
12. Name Robert Wheeler
13. Birthplace North Carolina

MOTHER
14. Maiden Name Shelly Zander
15. Birthplace Florida

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances R. Greenley
(b) Address 518 W. Baltimore St.

19 (a) 10-22-1946 (Date rec'd by registrar) (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 19 , to 10/17 19 , and that I last saw him alive on 19

Immediate cause of death Carcinoma of Esophagus with Metastasis of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Wigglesworth M.D. M. D.
Address 211 Light St. Date signed 10-19-46

Howard J. Maldeis MD for George B. Merrill MD X

VS 150

G44785

CWK-98140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G44785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9m 23d
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Boone Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15-1906

8. AGE: Years 40 | Months 9 | Days 6 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Boone
13. Birthplace Virginia

MOTHER
14. Maiden Name Leggin ??
15. Birthplace ?

16 (a) Informant Record-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-46 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Salem, N. J.

18 (a) Funeral director Mrs. Frances V. T. Hensley
(b) Address 548 W. Biddle St.

19 (a) 10-22-1946 (Date rec'd by Registrar) (b) Huntington Wilkerson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1946, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1945 to Oct. 21 1946, and that I last saw him alive on Oct. 21 1946

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration: 15 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Bird M. D.
Address Balto City Hosp. Date signed Oct 21, 1946

VS 150

X

44786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470

Registered No. G44786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 Mt Pleasant
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Mt Pleasant Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Schoch

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Schoch
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Sept 23 1891

8. AGE: Years	Months	Days	If less than one day
55	0	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Riveter Md Dry Dock
11. Industry or business

FATHER
12. Name Gottlieb Schoch
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Pitz meyer
15. Birthplace Germany

16 (a) Informant Charles Schoch
(b) Address 3231 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 Orleans St

19 Date received by registrar OCT 22 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 19 , at 9 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5- 1946 to 10-21 1946 and that I last saw h alive on 10-21 1946.

Immediate cause of death Carcinoma of lung.

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J Gould M D M. D.
Address 1714 Eastern Date signed 10-21-46

VS 150

X

G44787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V121a

G44787 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 W. 21st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W - 21st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Whitaker Meekins Greenstreet
(b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

(b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Johnsville Carroll Co Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

12. Name of father Lewis Whitaker

13. Birthplace of father Johnsville Carroll Co Md

14. Maiden name of mother Fannie Whitaker

15. Birthplace of mother Johnsville Carroll Co Md

16 (a) Informant John Whitaker
(b) Address 120 W - 21st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23-46 (month) (day) (year)
(c) Cemetery or crematory Johnsville Carroll Co Md
Location Carroll Co Md

18 (a) Funeral director Wm Brooks Ruggold
(b) Address 1637 N. Carey St

19 (a) Date rec'd by registrar OCT 22 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18-46 19 , at 5½ P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16-46 19 , to 10-18-46 19 , and that I last saw h[illegible] alive on 10-18 1946.

Immediate cause of death: Hypertension Cardio Renal Disease — Duration 2 yr.
Due to [redacted]
Due to
Other Conditions: Bronchitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Adams, M. D.
Address 312 E 23rd St Date signed 10-21-46

VS 1

4788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

G14788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 N. Stockton St
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1126 N. Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hence Nickens

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-3697

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mattie Nickens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Lancaster Co Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name James Nickens
13. Birthplace Lancaster Co Va
14. Maiden Name Sally Washington
15. Birthplace Lancaster Co Va

16 (a) Informant Mattie Nickens
(b) Address 2212 Hinson St

17 (a) Burial (b) Date thereof Oct 24 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1437 N. Carey St.

OCT 22 1946 (b) Huntington Mills Baltimore, Md.
(Date received by registrar)

VS 250

MEDICAL CERTIFICATION

8:42

20. DATE OF DEATH Oct 20 1946, at 8:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1946, to Oct 20 1946, and that I last saw h[illegible] alive on Oct 19 1946.

Immediate cause of death: (a) Carcinoma of Stomach — Duration 10 mos 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Stewart

Address 642 Franklin St Date signed Oct 21 D

X

4789

582663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Berkeley.
(c) City or town Martinsburg.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 W. King St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel J Strouse

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-91

8. AGE: Years	Months	Days	If less than one day
55.	2	23	hr. min.

9. Birthplace W. Va
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Elijah S. Tabler
13. Birthplace W. Va.

MOTHER
14. Maiden Name Catherine Whitmore
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-46 (month) (day) (year)
(c) Cemetery or crematory Martinsburg
Location Martinsburg, W. Va.
18 (a) Funeral director H. C. Hefner Estate
(b) Address Elliott City, Md.
19 OCT 22 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 21 1946 at 1135 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1946 to Oct. 21 1946, and that I last saw h[er] alive on Oct. 21 1946.

Immediate cause of death: Cerebral Edema — Duration 4 days.
Due to Hypertension
Cardiovascular Disease
Due to
Other Conditions Brain Tumor ?
(Include pregnancy within 3 months of death)
Date of operation Oct 15 + Oct 18.
Major findings of operation Mass
of autopsy: Refused.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature arthur s Strong
Address Johns Hopkins Hosp Date signed 10/24/46 M. D.

VS 150

X

44790 BALTIMORE CITY HEALTH DEPARTMENT G44790

CERTIFICATE OF DEATH 1930

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 W Hughes
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W Hughes (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth James

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clarence James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/7/1906

8. AGE: Years 39 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jake Glasco
13. Birthplace Md

MOTHER
14. Maiden Name Martha Robinson
15. Birthplace Md

16 (a) Informant Martha Vincent
(b) Address 554 Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L Brown
(b) Address 128 W Montgomery St

19 OCT 22 1946 Date rec'd by reg. Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1946 at 3:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/17/1946 to 10/18/1946 and that I last saw h[illegible] alive on 10/18/1946

Immediate cause of death

Paralysis

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Taylor

Address 152 N Washington Ave Date signed 10/21/46

14791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓469

G14791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 E. 29th St.
(c) Hospital or institution: 9th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 E. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME MARY BALLADARSCH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Frank Balladarsch
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 12, 1866
8. AGE: Years 79 | Months 10 | Days 7 | If less than one day: hr. min.
9. Birthplace: Austria (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. Frank Balladarsch
(b) Address: 630 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

OCT 22 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19, 1946, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Oct 19 1946, and that I last saw him alive on Oct 16 1946.

Immediate cause of death: Carcinoma of pancreas — Duration: 5 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Milton B. Kress X
Address: Frederick, Md. Date signed: Oct 21 1946

VS 150

44792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V87D

Registration No. 44792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2243 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2243 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Goldstone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Herbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 36 | Months | Days | If less than one day: hr. min.

9. Birthplace Marlinton W. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hime
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant: Dr Herbert Goldstone
(b) Address 2243 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-46 (month) (day) (year)
(c) Cemetery or crematory: Sherith Israel
Location: O'Donnell St

18 (a) Funeral director: Jack Lewis Inc
(b) Address 1809 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 22 1946 Huntington Willis

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21- 1946 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct 21 1946 and that I last saw her alive on Oct 20 1946

Immediate cause of death: Multiple Sclerosis — Duration: 6 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack Lewis

Address 1804 Eutaw Place Date signed 10/21/46 M. D.

X

G44793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓97

Registered No. G44793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street and number 4 Greenspring Ave
(c) Hospital or institution: Levindale

Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country

3 (a) FULL NAME Rachel Goffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Mrs Anna Benesch

(b) Address 4035 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)

(c) Cemetery or crematory Chevra Mevakrei Carmel

Location Baltimore

18 (a) Funeral director Joseph Kaufman Inc

(b) Address 1816 Dallas St

19 OCT 22 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1946, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1933 to 10-22 1946 and that I last saw h. alive on 10-22 1946.

Immediate cause of death	Duration
Generalized Arteriosclerosis Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin M.D.

Address Levindale Date signed 10-23-46

VS 180

4794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1457

G44794 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Hunter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Hunter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Montague

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1874

8. AGE: Years 72 | Months 7 | Days 12 | If less than one day: hr. min.

9. Birthplace Gloucester Virginia
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Humphrey Smith
13. Birthplace Va

MOTHER
14. Maiden Name Charlotte Smith
15. Birthplace Va

16 (a) Informant John Montague
(b) Address 2814 704 St

17 (a) Ships (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1946 (month) (day) (year)

(c) Cemetery or crematory
Location Gloucester Co Va.

18 (a) Funeral director Joyner Sanders
(b) Address 1412 E. Preston St.

19 (a) 22 1946 (Date received by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1946 to Oct 19 1946, and that I last saw h alive on Oct 19 1946.

Immediate cause of death: Resuscitation Obstruction — Duration: 1 year

Due to: Arteriosclerosis Coronary

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emerson P. Dalaire M. D.

Address 434 E. 20th St 18 Date signed 10/21/46

VS 150

4795 A30876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G44795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Highlandtown (If outside city or town limits, write RURAL and give town)
(d) Street No. 5703 Osprey Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Randolph

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-1941

8. AGE: Years	Months	Days	If less than one day
5	-	4	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Reno Randolph
13. Birthplace N.C.

MOTHER
14. Maiden Name Magnolia Jenkins
15. Birthplace N.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/46 (month) (day) (year)
(c) Cemetery or crematory Greenville N.C.
Location North Carolina

18 (a) Funeral director Leg. H. Kelson
(b) Address 1303 Pregelman Bldg

19 (a) OCT 22 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-20- 1946 at 5-05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18- 1946 to 10-20- 1946 and that I last saw him alive on 10-20- 1946.

Immediate cause of death Pulmonary edema — Duration

Due to Acute cardiac failure

Due to Acute glom. nephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Rinehart M. D.
Address Johns Hopkins Hosp Date signed 10-20-46

VS 150

4796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

T.N. 102684

Registered No. G41796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-mo, & 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elton Rice

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Sep
6 (b) Name of husband or wife: Lucy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 22/1914
8. AGE: Years 32 | Months 7 | Days 26 | If less than one day: hr. min.
9. Birthplace Va.
10. Usual Occupation Contractor
11. Industry or business

FATHER
12. Name Archie Rice
13. Birthplace Va.

MOTHER
14. Maiden Name Marie Taylor
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/46 (month) (day) (year)
(c) Cemetery or crematory Whitestone, Va
Location Va.
18 (a) Funeral director Wes. B. Nelson
(b) Address 1303 Greenleaf
(c) Date received by registrar OCT 22 1946 Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct /18/1946 19 , at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7th 19 46 to Oct 18 19 46 and that I last saw h im alive on Oct 18 19 46

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 5 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph H Bird M. D.
Address Balto City Hosps Date signed 10-21, 1946

VS 150

1797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1133a

Registered No. 681797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (months or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr George F Schaumann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27 1872

8. AGE: Years 73 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Customs Manager

11. Industry or business City Theatre

12. Name Conrad Schuermann

13. Birthplace Md

14. Maiden Name Elizabeth Schoenig

15. Birthplace Md

16 (a) Informant Emma M Schuermann

(b) Address 505 N Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc

(b) Address 1217 E Pratt St

19 (a) OCT 22 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1946 at 5.05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 5 1946 to Oct 21 1946 and that I last saw h.e alive on Oct 21 1946

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Primeplastic abscess

Due to: Arterio-sclerosis

Other conditions: Chr. Cystitis, Pyelitis

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: yes

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin Kamanks

Address St. Joseph Hospital Date signed 10/25/46

VS 150

4798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G44798
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Roma Russia

3 (a) FULL NAME Anthony Chepaitis also known as Chekaitis - Chepie

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 217-07-7572

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Alice Chepaitis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1879

8. AGE: Years 67 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Roma Russia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business 113 S. Howard St.

BOTHER'S / FATHER'S

12. Name Unknown

13. Birthplace

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Ruth A. Schmidt

(b) Address 1108 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director Clark W. Shellenberger

(b) Address 700 McCulloh St.

OT 22 1946 (c) (Local registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1946, at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1946 to Oct 19 1946 and that I last saw him alive on Oct 19 1946

Immediate cause of death Coronary Thrombosis — Duration 1 hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Ulrich Jr

Address 122 N Wash Blvd Date signed 10-20-46 M D

1799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G44799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & Slat St.,
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 Carlton St.,
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fisher, William

3 (b) If veteran, name war: WW 1

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1893 (?)

8. AGE: Years	Months	Days	If less than one day
53	2	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business --

FATHER
12. Name Dennis Fisher
13. Birthplace Anne Arundel Co., Md.

MOTHER
14. Maiden Name Julia Ranson
15. Birthplace Virginia

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto., Md.

17 (a) Burial (b) Date thereof Oct. 24, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 22 1946 (b) Huntington Williams
(Address City Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19th, 19 , at 8:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946, to Oct. 19 1946, and that I last saw h alive on 19 .

Immediate cause of death	Duration
Tuberculosis, pulmonary, chronic, right lung with empyema.	Several months.
Due to: Inanition.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 10/21/46

VS 180

800

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

G44800
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME ANITA MORGAN

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

(b) Name of husband or wife Walter Morgan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1915

8. AGE: Years 31 Months 2 Days 10 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name Thomas Nichols

13. Birthplace Md.

14. Maiden Name Rachel Conways

15. Birthplace Georgetown Md.

16 (a) Informant Mertona Evans

(b) Address 246 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1946 (month) (day) (year)

(c) Cemetery or crematory Georgetown Md.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 OCT 22 1946 (Date of the record) Huntington Wells Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1946 at 9.55 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet-wound through heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-19-46 at 9.45 P. M.
(b) Where did injury occur? 1515 E. Preston St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearms

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-21-46

VS 191

801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G41801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN E. WOOD

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Janet Wood (nee White)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Mrs. Janet Wood
(b) Address 1434 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 — 1946 at 2.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 - 1946 to Oct 19 - 1946 and that I last saw h[illegible] alive on Oct. 18 - 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. Atherosclerosis	
Due to	
Other Conditions Chronic Bronchitis w asthma, Chr. nephritis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Jacobs M. D.
Address 1700 Eutaw Pl. Date signed 10-24-46

VS 150

X

44802 BALTIMORE CITY HEALTH DEPARTMENT G44802

CERTIFICATE OF DEATH

Registered No. X 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: U. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town.)
(d) Street No. Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day hr.	min.
80?				

9. Birthplace Harford Co. Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Cabinet work

BOTHER FATHER
12. Name ?
13. Birthplace ?
14. Maiden Name
15. Birthplace

16 (a) Informant H. S. Bailey
(b) Address Darlington Md
17 (a) Burial (b) Date thereof Oct 25 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Darlington Cem
Location Harford Co. Md.
18 (a) Funeral director H. S. Bailey
(b) Address Darlington, Md.
19 Filed OCT 22 1946 Huntington Williams, M.D.

OCT 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1946, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1946 to 10/21 1946 and that I last saw h.i.m alive on 10/21 1946.

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Pulmonary embolus	
Due to Arteriosclerotic C.V.D., hepatomegaly	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert C. Kegaberg M.D.
Address U. Hosp. Balto Md. Date signed 10/22/46

X

4803 BALTIMORE CITY HEALTH DEPARTMENT G44803

CERTIFICATE OF DEATH 85

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 S. Decker Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 S. Decker Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Kwiatkowski
(b) If veteran, name war
3 (c) Social Security Account No. 212-10-2182

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
(b) Name of husband or wife Sophie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1891

8. AGE: Years 54 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business Wood Kraft Mf. Co.
12. Name Stanislaus Kwiatkowski
13. Birthplace Russia
14. Maiden Name Stanislawa Cafalska
15. Birthplace Russia
16. (a) Informant Sophie Kwiatkowski
(b) Address 716 S. Decker ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24 1946 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Mt. Carmel Rd.
18. (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.
19. (a) OCT 22 1946 (Registrar) Huntington Mills, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Oct 1946 at 8:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Hilleshe M.D.
Medical Examiner.
Date signed 21 Oct 46

VS 151

of the late Rose Levy Frank. Services at the Abrose Funeral Home, 3620 Reisterstown road, on Wednesday, October 23, at 4 P. M. Interment in Rodef Shalom Cemetery.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G44801

1. (a) Baltimore City, Maryland
(b) Street address SINAI HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 76 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO CITY.
(c) City or town BALTO-MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 NORFOLK AVE. 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOL FRANK.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced WIDOWER.

6 (b) Name of husband or wife ROSE FRANK.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY-26-1860

8. AGE: Years	Months	Days	If less than one day
85	5	25	hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation COLLECTOR.

11. Industry or business

FATHER
12. Name ABRAHAM FRANK.
13. Birthplace GERMANY

MOTHER
14. Maiden Name FANNIE STRAUSS
15. Birthplace GERMANY.

16 (a) Informant CAMILLA MINZ
(b) Address 3808 NORFOLK AVE.

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof OCT 23-46 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP CEM.
Location BALTO & CONKLING STS.

18 (a) Funeral director J. Ahrens.
(b) Address 3402 REISTERSTOWN RD.

19 (a) Date received by local registrar OCT 23 1946 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 21 19 46, at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 14 1946, to OCT 21 1946, and that I last saw h[illegible] alive on OCT 21 19 46

Immediate cause of death Acute Myocardial Infarction (Contusion)

Duration

Due to Coronary Thrombosis

Due to Arteriosclerosis of Coronary Arteries

Other Conditions Generalized Arteriosclerosis Bilateral Inguinal Hernia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Acute Contusion Myocardial Infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Forker M. D.
Address Sinai Hospital Date signed 10/24/46

VS 150

44805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G44805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 Vincent-st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 80A 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME William P. LEE

(b) If veteran, name war

3 (c) Social Security Account No. 214-14-5320

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced: Married

(b) Name of husband or wife Ernestine

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) ?? 1912

AGE: Years	Months	Days	If less than one day
34			hr. min.

Birthplace Johnson County N. C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Sylvester Lee

13. Birthplace N.C.

14. Maiden Name Flora J. Stewart

15. Birthplace N.C.

16 (a) Informant Edgar Lee

(b) Address Angier N. Carolina

17 (a) Removal (b) Date thereof Oct. 20 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Dunn N. Carolina

18 (a) Funeral director Mrs. E.A. Ellis & Dgt.

(b) Address 1129 N. Caroline St.

(c) OCT 22 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1946 at 1:30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of liver, with hemorrhage from ruptured esophageal varices.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/16/46

VS 151

44806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G44806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DA
(e) Length of stay in Baltimore (yrs., mos., or days) DA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 E. 20th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME JEAN CHANDLER

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Norval Chandler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14, 1900

8. AGE: Years 46 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace Kentucky

14. Maiden Name Unknown

15. Birthplace Kentucky

16. (a) Informant Norval Chandler

(b) Address 1115 E. 20th St.

17. (a) (Burial, cremation, or removal) (b) Date thereof 10/22/46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Oxford Street

18. (a) Funeral director Medairy Funeral

(b) Address 3446 Eighteenth Ave

19. (a) (Date rec'd by registrar) OCT 22 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/46 19 , at 5:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cancer of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Huy C. Ward M.D. Medical Examiner.

Date signed 10/17/46

VS 181

G44807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44807

163B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Temple Garden Apts.
(b) Street address Cloverdale & Druid Hill Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cloverdale & Druid Hill Park Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Regina Meyer Gruber
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

(b) Name of husband ~~or wife~~ Henry Gruber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1887

8. AGE: Years 59 | Months 3 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Israel Meyer

13. Birthplace Germany

14. Maiden Name Carrie Stern

15. Birthplace Germany

16. (a) Informant Mrs. M. Goldstrom (Sister)
(b) Address Temple Garden Apts.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/23/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18. (a) Funeral director Harris Lonaconing
(b) Address 1702 Eutaw Place

19. (a) Date received by registrar OCT 22 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1946, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Barbiturate poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/20/46 at apprx 5 P. M.
(b) Where did injury occur? Temple Garden Apt
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Swallowed Poison

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 10/21/46

VS 151

G44808

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G44808 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Ashton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Ashton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie L. Hoffmann - Blanchner

3 (b) If veteran, name war —— | 3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Andrew Hoffmann 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul 1-1866

8. AGE: Years	Months	Days	If less than one day
80	8	19	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name William Bruckmiller
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs John Himler
(b) Address 216 S Bilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 1512 Hollins St

19 (a) Date 10-23-1946 (registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1946, at 9 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Oct 20 1946. and that I last saw ... alive on Oct 19 1946

Immediate cause of death

	Duration
Hypostatic Pneumonia, Cardio Arterio-Sclerosis	
Due to Pulmonary Oedema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harford Bittenbender
Address 215 W Lafayette Ave Date signed 10-24-46

VS 150

X

44809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G44809
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dest-
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Charles Engelmeyer

(b) If veteran, name war

3 (c) Social Security Account No. 213-03-4508

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Mary Bannon Engelmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1888

8. AGE: Years 58 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

12. Name Jos. F. Engelmeyer

13. Birthplace Balto

14. Maiden Name Mary A. Werneg

15. Birthplace Balto

16 (a) Informant Mrs. Mary B. Engelmeyer

(b) Address 937 N. Calvert St

17 (a) Burial (b) Date thereof Oct 23, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Rita Wuchfeld

(b) Address 1006 Biddle St.

19 OCT 22 1946 (b)
(Date rec'd by registrar) Huntington Williams Jr

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1946, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gutwirth M.D.
Medical Examiner.
Date signed 10/22/46

VS 181

14810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 54a

G44810
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State West Virginia (b) County
(c) City or town Kinchelol
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louie Stutler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Edna Stutler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Abraham Stutler
13. Birthplace

MOTHER
14. Maiden Name Della Travis
15. Birthplace

16 (a) Informant Edna Stutler (wife)
(b) Address Kinchelol, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Kinchelow, W. Va.
Location Kinchelow W. Va.

18 (a) Funeral director Harwood D. Covington
(b) Address 21 W. 25th ST.
Huntington, Williamson, W. Va.

OCT 22 1946
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1946, at 12 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1946 to Oct. 21 1946
and that I last saw him alive on Oct 21 1946
Immediate cause of death Peripheral
Circulatory failure
Due to Shock
Due to Operation on brain tumor
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation Oct. 17 & Oct 20, 1946
Major findings of operation: Brain tumor
at frontal lobe.
of autopsy: None

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. McCord M. D.
Address University Hosp. Date signed 10-21-46

VS 150

X

G44811 G44811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325- M. Street, N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME John E. Held

(b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

(b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18 1899

AGE: Years 47 46 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation Jeweler

11. Industry or business Woodran & Lothrups

12. Name Henry W. Held

13. Birthplace Philadelphia, Penna.

14. Maiden Name Margaret Langgwood

15. Birthplace Baltimore, Maryland.

16 (a) Informant Anna Held

(b) Address 1802- 41st St.N.W. Wash

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10-24-46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland.

18 (a) Funeral director William Cook, Inc.

(b) Address 1217- St. Paul St.

Date 2 Oct 1946 (b) Huntington Williamsport

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1946 at 2.45 a. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-21-46 at Balto. Co. M.
(b) Where did injury occur? Eastern Ave. & Dorothy St. Essex,
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 10-21-46

BC# G52063 ✓ G44812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 64

G44812 Registered No.

PLACE OF DEATH:
) Baltimore City, Maryland
) Street address
) Hospital or institution: South Balto.Gen.Hospital D.O.A.
) Length of stay in hospital or inst. (yrs., mos., or days)
) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 William St.
(If rural give location)
) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Rose Marie Eid

(b) If veteran, name war

3 (c) Social Security Account No.

Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) 7/12/46

AGE: Years | Months 3 | Days 9 | If less than one day hr. min.

Birthplace Baltimore (Town, county, and state)

. Usual Occupation None
. Industry or business

12. Name Chas L. Eid
13. Birthplace Baltimore
14. Maiden Name Rose Mary Green
15. Birthplace Baltimore

(a) Informant Mr. C. L. Eid
(b) Address 295 William St.
(Buried (Burial, cremation, or removal) (b) Date thereof 10/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway
(a) Funeral director J. J. Daley Sons
(b) Address 1 W. Light St.
(a) Date rec'd by registrar 10-22-1946 Clayton Williams, Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1946 at 3 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymicolymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10/22/46

G44813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G44813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 E. Montgomery St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 E. Montgomery (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James A Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27-1860

8. AGE: Years 85 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Henson A Tucker

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Mary E. Tucker

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Harry Lentine

(b) Address 7320 Windsor Mill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24-1946 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Baltimore Md

18 (a) Funeral director Jeanette Cook & Syfer

(b) Address 1600 W. North Ave.

19 (a) Date received OCT 22 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1946 at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 21 1946.
and that I last saw h alive on Oct 20 1946

Immediate cause of death: Cardiac thrombosis | Duration 10 dy

Due to Senile Myocarditis | 10 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Randall K M. D.
Address 6 E. Randall St Date signed

VS 150

G44814 Kropp ✓ G44814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 Lee Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Lee St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME Andrew A. Kropa ✓

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Caroline
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/26/62.
8. AGE: Years 83 84 | Months 10 | Days 25 | If less than one day hr. min.
9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Margaret Beer
(b) Address 1618 Cypress St.
17 (a) Burial (b) Date thereof 10/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeem
Location Belair Rd.
18 (a) Funeral director Tilly & Zeiler
(b) Address 403 S. Wolfe St.
19 (a) (b) Date rec'd by registrar Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/1946 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/0 1946 to 10/21 1946, and that I last saw h[illegible] alive on 10/20 1946.

	Duration
Immediate cause of death: Acute Coronary Occlusion	1 day
Due to: Generalized Arterio-Sclerosis	
Due to:	
Other Conditions: Left hypo Lobar Pneumonia (Include pregnancy within 3 months of death)	10/0/46

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury Paul Luden
23. Signature M. D.
Address 320 Patapsco Ave Date signed 10/25/46

94a

G44815 BALTIMORE CITY HEALTH DEPARTMENT G44815
CERTIFICATE OF DEATH 61 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 S. Washington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Washington (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME PELAGIA ANUSZEWSKA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/10/1871

8. AGE: Years 74 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Kozlowski
13. Birthplace Poland

MOTHER
14. Maiden Name Barbara (Unknown)
15. Birthplace Poland

16 (a) Informant Viola Tribull
(b) Address 2631 Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Aye

18 (a) Funeral director Lilly & Zeiler, mc.
(b) Address 403 S Wolfe St.

19 (a) (Date received by registrar) (b) for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1946 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Oct 18 1946, and that I last saw h[illegible] alive on Oct 18 1946.

Immediate cause of death: Coronary Occlusion — Duration 6 yrs
Due to: Diabetes Mellitus — 3 yrs
Due to: Senile Changes
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1327 E Eutaw Pl Date signed 10/22/46

VS 150

G44816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. G44816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4209 Belleview
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 Belleview (If rural, give location)
(e) Citizen of foreign country? Britain (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. MARTIN
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
(b) Name of husband or wife Mary B. Martin
If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1878

8. AGE: Years 68 | Months 3 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business U. S. Army

12. Name Unknown
13. Birthplace England
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Mary B. Martin
(b) Address 4209 Belview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23/1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Ellsworth Funeral
(b) Address 3911 Liberty Heights Ave

OCT 22 1946 (b) [illegible] Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/46 19 . at 7:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Travers M.D.
Medical Examiner.
Date signed 10/21/46

X

G44817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G44817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA 11"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Cathedral
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME EDITH BOHANAN

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Walter P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1913

8. AGE: Years 33 | Months 5 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Edmund Hooper

13. Birthplace Md

14. Maiden Name Martha Wells

15. Birthplace Md

16 (a) Informant Mr. Edmund Hooper

(b) Address 1715 W. Lombard St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 23/46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Watts

(b) Address #101 Edmondson Ave.

19 (date received by registrar) OCT 22 1946 (Signature of registrar) Huntington Williams, M.D.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/46 19__, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/20/46 10 P.M.
(b) Where did injury occur? 905 Cathedral
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Turned on burners

23. Signature John L. Wallace, M.D.
(Medical Examiner)
Date signed 10/21/46

G14818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G14818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 50
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha B. Oliver

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widowed

6 (b) Name of husband or wife Oliver (late Solomosey) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1865

8. AGE: Years	Months	Days	If less than one day
81	8	12	hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation
11. Industry or business

INFORMATION FURNISHED BY PHYSICIAN

12. Name August Boeckel
13. Birthplace Germany
14. Maiden Name Unknown
15. Birthplace Germany
16 (a) Informant Mrs. Elverta Zebrauskas
(b) Address 2205 W. Fayette St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23/46 (month) (day) (year)
(c) Cemetery (or crematory) St. Paul's
Location Violetville
18 (a) Funeral director Harry H. Kuhle
(b) Address 4101 Edmondson Ave.
19 (a) (Date of this removal) (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20/46 19 , at M
21. I certify that death occurred on the date above stated; that I attended deceased from 7/ 22 19 46 to 10/ 20 19 46 and that I last saw h alive on 10/ 20 19 46.

Immediate cause of death	Duration
Acute Dilatation C.V.D.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Hamilton J. Johnson M. D.
Address 2331 Eutaw Pl Date signed 10/21/46

VS 150

Dr. Dunnigan
4944813

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G44819
Registered No.

121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4813 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie J. Pumphrey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Levi Lee Pumphrey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1856

8. AGE: Years	Months	Days	If less than one day
90?	2	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Lee Pumphrey
(b) Address 4813 Harford Road -14-

17 (a) Burial (b) Date thereof 10/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road.

19 (a) (b) Huntington Station Md.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21st 19 46, at 11.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Oct 17 1946, and that I last saw h.s.n alive on Oct 17 1946.

Immediate cause of death Uremia — Duration (months)

Due to Chronic nephritis — unknown

Due to Generalized arteriosclerosis — unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Dunnigan M. D.
Address 31 E. North Ave Date signed 10-31-46

VS 130

X

G44820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44820 Registered No. 1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7012 Hartland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert E. Farmer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Frances Farmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-1871

8. AGE: Years	Months	Days	If less than one day
75	—	15	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)
10. Usual Occupation Electrical Contractor
11. Industry or business

FATHER
12. Name Charles Farmer
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Collins
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5302 Harford Rd.

19 (a) 10/25 1946 (Date rec'd by registrar) (Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1946, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1946, to Oct. 24 1946, and that I last saw him alive on Oct. 24 1946.

Immediate cause of death: ? Coronary Occlusion; ? Cerebral Hemorrhage, Rupture

Due to Hypertrophied Ventricle, Brain, Cardiac failure.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/21/46

Major findings of operation: Hypertrophied Ventricle

Autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. W. Duncan
Address 1704 Date signed 10/27/46 M.D.

G. W. Duncan

VB 150

G44821 BALTIMORE CITY HEALTH DEPARTMENT X 937 G44821

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt. Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md.~~ Va (b) County
(c) City or town ~~Balto.~~ Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 W. 11th St. Norfolk, Va (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Karp
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Father Karp
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1866
8. AGE: Years 80 Months Days If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Jack Karp
(b) Address Portsmouth, N. J.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-22-46 (month) (day) (year)
(c) Cemetery or crematory Norfolk, Va
Location
18 (a) Funeral director Jos. Lewis Inc
(b) Address 1439 E. Balto. St
19 (a) 10-23-1946 (Date received by registrar) Livingston Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22- 1946 at 6 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1946 to 10/21 1946, and that I last saw him alive on 10/21 1946

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Ch myocardial degeneration	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —
23. Signature A. A. Hornstein M. D.
Address 733 Augusta St Date signed 10/23/46

VS 180

X

G44822 F47808 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH V12 G44822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution:
Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1339 W. Fremont Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Earl Young

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/9/42 4/9/42

8. AGE: Years	Months	Days	If less than one day
4	6	3	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Norman Young
13. Birthplace Virginia

MOTHER
14. Maiden Name Viola Brandt
15. Birthplace N. C.

16 (a) Informant Viola Young
(b) Address 1339 W. Fremont Ave

17 (a) — (Burial, cremation, or removal) (b) Date thereof 10/24/46
(c) Cemetery or crematory
Location Carlton

18 (a) Funeral director Chas H. Alexander
(b) Address 120 W. Mulberry St

19 (a) — (b) Harrington Williams, Registrar
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1946 at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1946 to 10-21 1946 and that I last saw him alive on 10-21 1946.

Immediate cause of death Pulmonary Failure — Duration

Due to Pertussis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Ed Driggs, M.D.
Address Univ Hosp Date signed 10-21-46

VS 150

X

G44823 BALTIMORE CITY HEALTH DEPARTMENT G44823
Registered No.

CERTIFICATE OF DEATH 92 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County 320 Chesterfield Ave Balto. Md
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Chesterfield ave, Balto, Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Wheeler.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1914

8. AGE: Years 42 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Hennenville St Mary's Co. Md
(Town, county, and state)
10. Usual Occupation Laborer,
11. Industry or business

FATHER
12. Name P.C. Wheeler
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. McKay
15. Birthplace Md

16 (a) Informant P.C. Wheeler
(b) Address Hennenville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Great Mills, Md

18 (a) Funeral director W. C. Maltbyly Sons
(b) Address Leonardtown, Md.

19 (a) 10-22-1946 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 October 1946 at 9:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 June 1946 to 22 Oct, 1946.
and that I last saw h[illegible] alive on 22 Oct, 1946.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Rheumatic C.V. Disease, Cardiac Enlargement.	
Due to Aortic Stenosis + Insuff. Mitral Stenosis.	
Other Conditions Contributing to Death but not related to Endocarditis	

Date of operation
Major findings of operation:
of autopsy: above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester G. Shaw M. D.
Address West Balto Gen Hosp. Date signed 10/24/46

VS 150

G44824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

G44824
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 S Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME William Crist

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced: Married

(b) Name of husband or wife Frances

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 14, 1887

8. AGE: Years 59 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business

12. Name Felix Crist

13. Birthplace Poland

14. Maiden Name UNKNOWN

15. Birthplace Poland

16 (a) Informant Mrs. Frances Crist
(b) Address 2031 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rood
Location Jensen Hill Road

18 (a) Funeral director W. J. Schmidt & Sons
(b) Address 1808 Eastern Ave.

19 (a) 10 22 1946 (Date received by registrar) (b) Lewis Washington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Oct 1946 at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carcinoma of Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Kelly M.D.
Medical Examiner.
Date signed 21 Oct 46

G44825 BALTIMORE CITY HEALTH DEPARTMENT G44825
CERTIFICATE OF DEATH 1310 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Belvieu Ave 7
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4601 Belvieu Ave 7 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Bruce Hart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha Hart 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1878

8. AGE: Years	Months	Days	If less than one day
68	10	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Hart
13. Birthplace Maryland

MOTHER
14. Maiden Name Wingate
15. Birthplace Maryland

16 (a) Informant Bertha Hart
(b) Address 4601 Belvieu Ave 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24/46 (month) (day) (year)
(c) Cemetery or crematory Dorchester Memorial Location Cambridge, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.
OCT 22 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/46 19 at 9.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 9, 1946 to Oct. 22 1946, and that I last saw him alive on Oct. 22 19 46.

Immediate cause of death	Duration
Myocardial Failure and Uremia	
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to and Chronic Nephritis	

Other Conditions Generalized arteriosclerosis. X Ray — enlarged heart & dilatation of aorta.
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation? —
of autopsy? —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature H. Williams Huntington M. D.
Address Franklin Sq. Hosp. Date signed 10/22/46

S44826 — BALTIMORE CITY HEALTH DEPARTMENT — G44826

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broening Highway-
(c) Hospital or institution: Western Electric Co. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Eutaw Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Joseph D. Adelsberger

(b) If veteran, name war: World - (2)

(c) Social Security Account No. 220-16-0748

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 - 1925

8. AGE: Years 21 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Frederick Co Md
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business S.A. Williams Co

12. Name Joseph Adelsberger

13. Birthplace Frederick Co Md

14. Maiden Name Alaidia Wee

15. Birthplace Balto Md

16 (a) Informant S.L. Allison

(b) Address Emmitsburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 46 (month) (day) (year)

(c) Cemetery or crematory St Joseph's Cemetery
Location Emmitsburg Md

18 (a) Funeral director William Roth Inc

(b) Address 1217 St Paul St

19 (a) OCT 23 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1946, at 8.42 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Suffocation (mechanical)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-22-46 8 a. M.
(b) Where did injury occur? Broening Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Windows fell on him

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-22-46

VS 19!

G44827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registration No. G44827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Southard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband Samuel C. Southard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2nd 1859

8. AGE: Years	Months	Days	If less than one day
87	3	20	hr. min.

9. Birthplace Charlestown W. Va.
(Town, county, and state)
10. Usual Occupation Patient
11. Industry or business Nursing Home

FATHER
12. Name Unknown O'Connell
13. Birthplace "

MOTHER
14. Maiden Name Mary "
15. Birthplace "

16 (a) Informant Mrs Genevieve Kane
(b) Address 411 S. Monroe St.

17 (a) Burial (b) Date thereof 10/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 22 1946 (b) Waiting for Williams
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22nd 1946; at 8 20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to Oct 22 1946, and that I last saw h[illegible] alive on Oct 21 1946.

Immediate cause of death	Duration
ARTERIO SCLEROTIC HEART DISEASE	5 yrs.
Due to GENERALIZED ARTERIOSCLEROSIS	20 yrs
Due to	
Other Conditions SENILE ARTHRITIS	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Norman R. Klemm M. D.
Address 3803 Edmondson Ave. Date signed 10/24/46.

VS 150

G44828

HB 105451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 12-15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 North Point Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Cleveland Maddox

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-2076

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Flossie Maddox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/08

8. AGE: Years	Months	Days	If less than one day
38	9	25	hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation Inspector
11. Industry or business General Motors

FATHER
12. Name ? Maddox
13. Birthplace Fla.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Balto. City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/46 (month) (day) (year)
(c) Cemetery or crematory Oakland Cemetery
Location PERRY, FLORIDA

18 (a) Funeral director John F Kenny
(b) Address 715 Light St.

19 (a) (b) Registrar

OCT 23 1946 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 22, 19 46 at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22, 19 46 to Oct. 22, 1946. and that I last saw h alive on Oct. 22, 19 46.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertension & Valvular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Walker M. D.
Address B. C. H. Date signed 10/22/46

X

44829 G44829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWX-104995 52B Registered No. 265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Worcester
(c) City or town Stockton (If outside city or town limits, write RURAL and give town)
(d) Street No. None (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Henry Thomas Allen

3 (b) If veteran, name war ..... 3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Cissie (D)
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 17-1881 (1881)

8. AGE: Years	Months	Days	If less than one day
65	3 (4)	0 28	hr. ..... min. .....

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Aleck Allen
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Whittington
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Home Beneficial Cem
Location Stockton, Md

18 (a) Funeral director H. Harvey Bradshaw
(b) Address Crisfield Md

19 (a) 10/21/46 (Date rec'd by registrar) (b) E. C. Dise M.D. (Registrar)
Huntington Williams, Md

OCT 23 1946

MEDICAL CERTIFICATION 1946 P

20. DATE OF DEATH October 15 19 46 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 19 46 to Oct. 15 19 46, and that I last saw h im alive on Oct. 15 19 46.

Immediate cause of death Peritonitis.

Due to rupture of bladder at site of adenocarcinoma of Dome Bladder wall.

Other Conditions Bilateral hydronephrosis. Cystitis.
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: As above.

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature R. B. Tibbs M. D.
Address Baltimore City Hosp. Date signed 10/19/46

X

29 42 E. Fayette St.

G44830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G44830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N. Curley Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Curley Street (If rural give location)
(e) Citizen of foreign country? N (Yes or No) If yes, name country

3 (a) FULL NAME Teresa Voith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Anton Voith (deceased) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1865

8. AGE: Years	Months	Days	If less than one day
81	6	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Micheal Buehl
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Brickel
15. Birthplace Germany

16 (a) Informant Mrs. O'Neal (Niece)
(b) Address 2406 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/'46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Germinhill Road

18 (a) Funeral director Libby & Zeiler Inc.
(b) Address 403 S. Wolfe Street

19 (a) (b) Registrar

MEDICAL CERTIFICATION P/

20. DATE OF DEATH October 20, 1946 at 3:45/ M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17, 1946, to Oct. 20, 1946, and that I last saw her alive on Oct. 20, 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philbert Antzjevski M.D.
Address 2942 E. Fayette St. Date signed 10/21/46

VS 190

X

G44831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G44831 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Aves.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give County)
(d) Street No. 1721 No Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM SHAPIRO

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Eva
15. Birthplace Russia

16 (a) Informant Rose Shapiro
(b) Address 1721 No Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-46 (month) (day) (year)

(c) Cemetery Crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis & Sons
(b) Address 1698 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS rev OCT 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1946 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1946 to Oct 22 1946 and that I last saw him alive on Oct 22 1946.

Immediate cause of death: Myocardial Infarction — Duration

Due to Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Burwitch M.D.
Address 3706 Rosedale Rd Date signed 10/25/46

X

G44832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V137a

Registered No. G44832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Tudor Arms apts (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Phillips Lee Goldsborough

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	widowed

6 (b) Name of husband or wife Mary Ellen Stowell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1865

8. AGE: Years	Months	Days	If less than one day
81	2	16	hr. min.

9. Birthplace Cambridge Md (Town, county, and state)
10. Usual Occupation Director of Federal Department
11. Industry or business Naval Corps

FATHER
12. Name Martin W. Goldsborough
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Mattie McJones
15. Birthplace Princess Anne Md

16 (a) Informant Phillips Lee Goldsborough
(b) Address 4400 Huckleberry Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24/46 (month) (day) (year)
(c) Cemetery or crematory Christ Church Cemetery
Location Cambridge Md

18 (a) Funeral director John P. Mitchell Sons
(b) Address 408 Dutton Place

19 (a) (Date received by Registrar) OCT 23 1946 (b) Huntington Williams M.D. (Signature of Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1946 to 10-22 1946, and that I last saw h.i.h.a. alive on Oct 22 1946

Immediate cause of death: Acute coronary thrombosis
Due to: Coronary sclerosis
Due to:
Other Conditions: post-op paralytic ileus
(Include pregnancy within 3 months of death)
Date of operation 11 October 1946
Major findings of operation: Resection prostatic hypertrophy
of autopsy: Inferior myocardial infarction

Duration
24 hrs.
:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Minister Kennard Jr. M. D.
Address Dr. Union Mem. Hospital Date signed 10-22-46

X

G44833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44833 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital D.O.A. 9-14-46
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Ridgewood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robinson C. Pagon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Margaret P. Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 29, 1883

8. AGE: Years 63 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: dry goods

11. Industry or business

FATHER
12. Name: William H. Pagon
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Caroline Hooper
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Margaret D. Pagon
(b) Address: 209 Ridgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/46 (month) (day) (year)
(c) Cemetery Loudon Park
Location: 3801 Frederick Road

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 (a) OCT 23 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1946 1 P. M

21. I certify that I took charge of the remains described above, held an inspec.&inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/25/46

VS 181

G44834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G44834 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Dolphin St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Forrest A. Wessells

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife Peggy A. Baba
6 (c) If widow, give age 58 years

7. Birth date of deceased (mo., day, yr.) AUG. 19-1902

8. AGE: Years	Months	Days	If less than one day
44	2	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Dorsey A. Wessells
13. Birthplace Va.

MOTHER
14. Maiden Name Lula H. Taylor
15. Birthplace Va.

16 (a) Informant Peggy B. Wessells
(b) Address 316 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24/46 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Road
18 (a) Funeral director John O. Mitchell & Sons
(b) Address 304 Eutaw St.
19 (a) OCT 23 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1946 to Oct. 21 1946. and that I last saw h living on Oct. 21 1946.

Immediate cause of death	Duration
Cachexia - Cardiocirculatory collapse	
Due to Extensive Carcinoma of liver, secondary to	
Due to primary adenocarcinoma of rectum.	
Other Conditions Jaundice	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: As stated above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John F. Noguera M. D.
Address Md. Gen. Hosp. Date signed 10/22/46

VS 190

44835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44835 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenore E. Bauer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE Years	Months	Days	If less than one day
About 57 years	None Known		min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER - FATHER

12. Name John Bauer
13. Birthplace Germany

14. Maiden Name Elise L. Frelling
15. Birthplace Germany

16 (a) Informant Mrs Minnie F. Baker
(b) Address 2704 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Mathias Lamoreau
(b) Address 3010 Liberty Heights Ave.

OCT 23 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1943 to Oct 20 1946; and that I last saw her alive on Oct 20 1946.

Immediate cause of death	Duration
arteriosclerotic cardio Vascular disease	3 years.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kupp, M.D.
Address 3030 Edmondson Ave. Date signed 10/21/46

VS 150

4836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

G44836
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapel Gate Lane
(c) Hospital or institution:
Pine Crest Sanitorium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Poplar Grove Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Clarke (Nellie Catherine Clarke)

3 (b) If veteran, name war	3 (c) Social Security Account No. 212-03-6502

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1894

8. AGE: Years	Months	Days	If less than one day
52	2	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Telephone Operator
11. Industry or business Homewood Apartments

FATHER
12. Name Charles E. Clarke
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Ellen Dwyer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catherine C. Russ
(b) Address Tenth St. East Ocean View, Norfolk, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Thompson
(b) Address 1003 N. Baltimore St.

19 OCT 23 1946 (b) Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to 10/21 1946 and that I last saw h.er alive on 10/21 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to

Due to

Other Conditions: Arteriosclerosis — Duration: 2 yrs
Will to operation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. Balagia M. D.
Address 3326 Frederick Ave. Date signed

VS 180

837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 834837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 W. Mulberry D.S.H.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaiah Seeney Seney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Maggie

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10-1887

8. AGE: Years 59 Months Days 10 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business B.&O. R.R.

12. Name Solomon Seeney

13. Birthplace Md

14. Maiden Name Henrietta S. Chase

15. Birthplace Md.

16 (a) Informant Clifton Seeney

16 (b) Address 1639 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-46 (month) (day) (year)

17 (c) Cemetery or crematory Arlington

Location Balto. Co.

18 (a) Funeral director Saml. W. Chase & Son

18 (b) Address 638 N. Gilmor St.

19 (a) OCT 23 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1946 at 6:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Lubinski M.D.
Medical Examiner.
Date signed 10/20/46

VS 191

G44838 | BALTIMORE CITY HEALTH DEPARTMENT | G44838

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution:
Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs (12)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Lynch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife John Lynch
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-18[illegible]

8. AGE: Years 60 | Months 7 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Balto Md.
(City, town, county, and State)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Nicholas Carter
13. Birthplace Md.

MOTHER
14. Maiden Name Betts
15. Birthplace Md.

16 (a) Informant Mabel Hawkins
(b) Address 1624 Druid Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Wm. Frazier R. Williams
(b) Address 32 & W. Baltimore Sts

19 (a) Oct 22 1946 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22-46 1946 at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1946, to 10-22 1946, and that I last saw her alive on 10-22 1946.

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of cervix	
Due to	
Other Conditions Congestive heart failure	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Not granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. H. F. Phillips / D. Pinkett M.D.
Address 1514 Division St Date signed 10-22-46

X

G44839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2313 Fleet Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Fleet Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Katherine Trawinski (or) Gora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-18-1865

8. AGE: Years 81 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Studzinski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Joseph Gore (Son)
(b) Address 2313 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George R. Weber
(b) Address 705 South Ann Street

OCT 23 1946 (Date received by local Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22nd 1946, at 3.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946, to Oct. 22 1946, and that I last saw him alive on Oct 22 1946

	Duration
Immediate cause of death: Cerebral hemorrhage	6 days
Due to: Cardio vascular disease & hypertension	years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Nowak, M.D.
Address 4085 Patterson Ave. Date signed 10/22/46

VS 3

G44810 BCH

$53440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G44810

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Brown.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	Black.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-46

8. AGE: Years	Months	Days	If less than one day
	2.	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Brown.
13. Birthplace Va.

MOTHER
14. Maiden Name Elsie. 2.
15. Birthplace Md

16 (a) Informant Relative.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wood
(b) Address 1000 Greenleigh Ave

19 (a) 1946 Oct 23 Walter Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1946, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1946, to Oct. 22 1946, and that I last saw him alive on Oct. 22 1946.

Immediate cause of death	Duration
Marasmus	
Due to Malnutrition	
Due to Diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

Signature Richard E. Dorrance M.D.
Address Johns Hopkins Hosp. Date signed 10/23/46

VS 150

G44811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44811 Registered No.

EB #103392 132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 20
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1899

8. AGE: Years	Months	Days	If less than one day
47	8	14	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Rogers
13. Birthplace S. C.

MOTHER
14. Maiden Name Hattie Schrles
15. Birthplace S. C.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave. Oct. 26, 1946

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1008 Brantley ave

19 (a) (b)
(City or county registrar) Registrar

Huntington Hillsdale, Md

MEDICAL CERTIFICATION 1946 P

20. DATE OF DEATH Oct. 21, 1947 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1946 to Oct. 21, 1946 and that I last saw h. im alive on Oct. 21, 1946

Immediate cause of death	Duration
Pulmonary Embolism	2 hours
Due to Thrombophlebitis, Right leg	1 month
Due to	
Other Conditions Pulmonary Tuberculosis Far advanced (Include pregnancy within 3 months of death)	6 months

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Bird M. D.
Address Balto City Hosps Date signed 10-22-46

VS 150

100 B

G44812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G44812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244 Asquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 Asquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgianna Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16, 1876

8. AGE: Years 70 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace St Marys County Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Robinson
13. Birthplace Md

MOTHER
14. Maiden Name Silvia Blackwell
15. Birthplace Md.

16 (a) Informant Silvia Johnson Alic
(b) Address 244 Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md

18 (a) Funeral director Mrs L.M.A. Elliott Dept
(b) Address 1129 N. Carlin St.

19 (a) OCT 23 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1946 at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946 to Oct 21 1946, and that I last saw him alive on Oct. 21 1946.

Immediate cause of death: Uremia — Due to: Chr. Nephritis — Due to: Arterio-sclerosis

Duration
2 days
1 day
?
?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Berry M. D.
Address 1420 E. Chase Date signed 10-22-46

VS 150

4813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G44813 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1796 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1796 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Caw

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1896

8. AGE: Years 50 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Rock, Md. (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Otho
13. Birthplace Rock, Md.

MOTHER
14. Maiden Name Mary R. Jackson
15. Birthplace Upshur, Md.

16 (a) Informant Mrs. Eleanor Cooper
(b) Address 1796 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Rock Cemetery
Location Rock, Md.

18 (a) Funeral director Mrs. George H. Hallowell
(b) Address 1091 Druid Hill Ave

19 (a) OCT 23 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 20 1946, and that I last saw her alive on Oct 20 1946.

Immediate cause of death: Cerebral hemiplegia — Duration 2 days
Due to Arteriosclerosis
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Beryl Pendleton M. D.
Address 1723 Druid Hill Ave Date signed 10-23-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G44844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8-2a

G44814
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Alhambra Apartments
(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore - 17 - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Alhambra Apartments
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Isaac David Rogers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Rachael Minnie Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/14/1870

8. AGE: Years 76 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Harris B. Rogers
13. Birthplace Russia

MOTHER
14. Maiden Name Rosie Eastern
15. Birthplace Russia

16 (a) Informant Sol Rogers
(b) Address 925 Brooks Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1419 E Balto St

19 (a) (b)
OCT 23 1946
Huntington-Williams, Inc.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1946 at 4:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Oct 22 1946, and that I last saw h[illegible] alive on Oct 22 1946.

Immediate cause of death: Arteriosclerosis
Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions: Acute Cardiac dilatation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadrie M. D.
Address 2306 Eutaw Pl Date signed 10-22-46

X

G44845 BALTIMORE CITY HEALTH DEPARTMENT G44845

HB # 105120 CERTIFICATE OF DEATH 93c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Bogdan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna Bogdan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1913

8. AGE: Years	Months	Days	If less than one day
33	4	7	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Electric Welder
11. Industry or business Shipbuilding

FATHER
12. Name Peter Bogdan
13. Birthplace Poland

MOTHER
14. Maiden Name Roselie Augustyn
15. Birthplace Poland

16 (a) Informant Balto. City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M.F. Sadowski & Sons
(b) Address 1805 Eastern Avenue

19 (a) OCT 23 1946 Washington Williams M.D.
(Signature and title of local registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 21, 1946, at 10:10M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1946 to Oct. 21, 1946 and that I last saw him alive on Oct. 21, 1946.

Immediate cause of death Myocardial failure — Duration
Due to Rheumatic C-V disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Wallace
Address B. C. H. Date signed 10/22/46

VS 150

X

G44816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G44816 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 47y

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town 3 1631 ALICEANNE ST (If outside city or town limits, write RURAL and give town)
(d) Street No. BALTIMORE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT SIENKIEWICZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced FELIKSA

6 (b) Name of husband or wife FELIKA

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 3/15/1875

8. AGE: Years 71 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace POLAND (town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER: 12. Name SIENKIEWICZ
13. Birthplace POLAND

MOTHER: 14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant MRS. FELIKSA SIENKIEWICZ
(b) Address 1631 ALICEANNA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director M. F. Padonah's Sons
(b) Address 1808 Eastern Avenue

19 (a) (Date received by registrar) (b) Signature of Registrar

23 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1946 at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1946 to 10-21 1946 and that I last saw h. Walive on 10-21 1946.

Immediate cause of death: Cardiorespiratory failure — Duration
Due to Uraemia
Due to Carcinoma Stomach
Other Conditions METASTASIS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells M. D.
Address 5803 Hoff Date signed 10-21-46

G44817

BALTIMORE CITY HEALTH DEPARTMENT (over) G44817
CERTIFICATE OF DEATH 52 B
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4505 Springdale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4505 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wiencke

3 (b) If veteran, name war	3 (c) Social Security Account No. 215-18-3791

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Barbara M. Wiencke
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) December 24, 1871

8. AGE: Years	Months	Days	If less than one day
74	9	28 29	hr. 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Plaza Barber Shop

FATHER
12. Name Frederick Wiencke
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant: Mrs. George Wiencke
(b) Address 4505 Springdale Ave.

17 (a) Burial (b) Date thereof Oct. 25, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.
18 (a) Funeral director C. Willis Lonsdale
(b) Address 4510 Liberty Heights Ave.
19 (a) (b) Registrar
(Date rec'd by registrar)

OCT 23 1946 Huntington Williams, M.D.
VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1946 at 8.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1942 to Oct 1946 and that I last saw him alive on 10-19- 1946.

Immediate cause of death: Carcinoma of bladder - metastasis
Due to: in past 3-4 months to stomach - liver
Due to: Duration: 4 years
Due to: 1 month
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. V. Harper M. D.
Address 5201 Gwynn Oak Ave. Date signed 10/23/46

X

G44818 G44818

503 11b

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Worrall

3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	unknown

6 (b) Name of husband or wife unknown
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-25-10

8. AGE: Years	Months	Days	If less than one day
35 86	9	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation unknown
11. Industry or business unknown

FATHER
12. Name William Bracenage
13. Birthplace md.

MOTHER
14. Maiden Name Cornelia Wheeler
15. Birthplace md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 27, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Denton
Location Denton, Md.

18 (a) Funeral director J. Virgil Hance & Son
(b) Address Denton, Md.

19 (a) (b) Huntington Williams, M.D.
Filed by registrar Registrar

20. DATE OF DEATH Oct-23 1946, at 4.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1946 to Oct 23 1946, and that I last saw him alive on Oct 23 1946,

Immediate cause of death	Duration
Bronchopneumonia terminal - Uremia	4d
Due to Secondary anemia	2 mo
Due to Carcinoma, Cervix Leagues of Nations 14	? 8 mo
Other Conditions Bilateral Hydronephrosis	

(Include pregnancy within 3 months of death)
Date of operation 9/19/46
Major findings of operation: Bleeding Cervical Cancer
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Easton Long M.D.
Address The John Hopkins Hosp Date signed 10/25/46

OCT 28 1946

VS 150

G44819 BALTIMORE CITY HEALTH DEPARTMENT G44819

CERTIFICATE OF DEATH 77E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N.Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown.- Found-2510 Loch Raven Blvd. (If rural route, give number)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEPHEN J. SCALES (Stephen C.Scales)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.18,1900

8. AGE: Years 46 Months 9 Days 3 If less than one day ######## min.

9. Birthplace Baltimore,Md. (Town, county, and state)

10. Usual Occupation Plumbers helper

11. Industry or business Plumbing

FATHER

12. Name Stephan G.Scales

13. Birthplace Baltimore,Md.

MOTHER

14. Maiden Name Margaret M.Connelly

15. Birthplace Baltimore,Md.

16 (a) Informant James J.Scales.-Brother

(b) Address 1246 Hargest La.Balto:Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Avenue

18 (a) Funeral director George J.Ruth,Inc.

(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1946, at 9 a.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cerebral edema

Due to History of Alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 10/21/46

VS 191

G44850 BALTIMORE CITY HEALTH DEPARTMENT G44830

CERTIFICATE OF DEATH X 52 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st Steet
(c) Hospital or institution:
U.S.Marine Hospital, Baltimore 11, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ~~Montgomery~~ 2
(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4837 Leland Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Van Pelt, Stella

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1893

8. AGE: Years	Months	Days	If less than one day
53	3	19	hr. min.

9. Birthplace Lexington, Kentucky
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business --

FATHER
12. Name Fred Van Pelt
13. Birthplace Kentucky

MOTHER
14. Maiden Name Kate Broadus
15. Birthplace Kentucky

16 (a) Informant Records
(b) Address U.S.Marine Hospital, Balto, Md.

17 (a) Cremated in Baltimore Md. thereof 10/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore Md.

18 (a) Funeral director Gardner Funeral Home
(b) Address Baltimore Md.

19 (a) 10-23-1946 (b) Huntington Willis
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 19 46 at 9:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 19 46 to Oct. 23 19 46 and that I last saw h er alive on Oct. 23 19 46

Immediate cause of death: Pelvic abscess — ?
Due to: carcinoma of urinary bladder ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As Above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis L. Van Pelt

Address U.S.M.H. Balto Md. Date signed 10/23/46

VS 180

F-44851 DCM Birth 05945 CORRECTED COPY F-44851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Grave Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Homestead St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hough

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1946

8. AGE: Years — Months — Days 5 If less than one day hr. min.

9. Birthplace 1132 Homestead Street (Town, county, and state)

10. Usual Occupation infant

11. Industry or business —

FATHER
12. Name John H. Hough
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name Irene Hough
15. Birthplace NOT KNOWN.

16 (a) Informant Records of University Hospital
(b) Address Baltimore, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 22 1946

18 (a) Funeral director

(b) Address

19 OCT 24 1946 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1946 to Oct 17 1946, and that I last saw him alive on Oct 17 1946

Immediate cause of death: Cardio vascular Collapse — Duration: 1

Due to Subarachnoid hemorrhage

Due to Cerebral birth trauma

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy Subarachnoid hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas H. Godwick

Address University Hospital Date signed 11/21/46

VS 190

44851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G44851 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Newborn (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Homestead Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy "A" Hough.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age —years

7. Birth date of deceased (mo., day, yr.) OCT 14, 1946

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation X

11. Industry or business

FATHER 12. Name Charles Fisher

13. Birthplace Va

MOTHER 14. Maiden Name Viola Edmonds

15. Birthplace Va

16 (a) Informant —

(b) Address —

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 24 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Oct '46 19 , at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Oct 19 46 to 17 Oct 19 46, and that I last saw him alive on 17 Oct 19 46

Immediate cause of death: Cerebral birth Trauma - probably Cerebral hemorrhage — Duration: 1

Due to causing persistent apnoea + terminal respiratory

Due to failure.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Results of autopsy: Cerebral hemorrhage

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R.E. Bonner M. D.

Address University Hosp Date signed 17 Oct '46

OCT 22 1946 Commissioner of Health

VS 150

1852 Bd. 9-0790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G11852 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Orford St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gail Lee

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4:15 PM Oct 18 1946

8. AGE: Years	Months	Days	If less than one day
		1/3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Otis Lee
13. Birthplace N.C.

MOTHER
14. Maiden Name Edith Maxine Butler
15. Birthplace Roberts Town, Miss

16 (a) Informant Edith Lee
(b) Address 503 Orford St, Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 OCT 24 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1946 at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1946 to 10/19 1946 and that I last saw him alive on 10/19 1946

Immediate cause of death Pneumatosis Cystoides Intestinalis (2-4)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Brown M. D.
Address Johns Hopkins Hospital Date signed 10/19/46

OCT 22 1946
Commissioner of Health

X

~~44853~~ G44853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44853

~~DC#~~ D59200 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 464 Cumming Court (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Baby J Laurdia Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/46 10-16-46

8. AGE: Years	Months	Days	If less than one day
		3 2	hr. min.

9. Birthplace Balto. md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Steven Harrison
13. Birthplace Pa.

MOTHER
14. Maiden Name Lucinda Davis
15. Birthplace N.C.

16 (a) Informant Laurdia Harrison
(b) Address 464 Cumming Court.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 21 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 24 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16- 1946, at 5 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14- 1946, to 10-16- 1946, and that I last saw her alive on 10-16 1946.

Immediate cause of death Atelectasis — Duration

Due to prematurity — 36 wks. (?)

Due to Premature Delivery

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hobart Cowie M.D.

Address 1131 Harlem Ave. 10/20/46

14854 BC# D58206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G14854 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dunbland & Rayner Ave
(c) Hospital or institution: West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 7516 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy MATHENY
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-46

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 8 hr. 0 min.

9. Birthplace BALTimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Douglas MATHENY
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 21 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 24 1946 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1946 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1946 to 10-3 1946. and that I last saw him alive on 10-3 1946.

Immediate cause of death — Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Berdinsky
Address 7516 Belair Rd Date signed 10-24-46

VS 150

1855 BC# 59719 BALTIMORE CITY HEALTH DEPARTMENT ✓ C81855

CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 N. Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Bruce St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emory Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-46

8. AGE: Years	Months	Days	If less than one day
0	0	0	16 hr. 0 min.

9. Birthplace Baltimore - 17, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Archie Clayton
13. Birthplace Colemans, Md.

MOTHER
14. Maiden Name Edna Gibbs
15. Birthplace Colemans, Md

16 (a) Informant mother
(b) Address 1304 Bruce St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY OCT 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 24 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-46 at 3.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1946 to 10-17 1946. and that I last saw h.im alive on 10-17 1946

Immediate cause of death
(a) Traumatic Hemorrhage
Due to injuries suffered at birth
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman L. Harrison
Address University Hosp. Date signed 10/19/46

VS 150

G44856 BALTIMORE CITY HEALTH DEPARTMENT G44856
CERTIFICATE OF DEATH 55E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ROCHAMBEAU APARTMENT
(b) Street address FRANKLIN & CHARLES STREET.
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. CHARLES & FRANKLIN STREET
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME PHILOMENZA D UNVERZAGT. (Philomena)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: William J. Unverzagt
6 (c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) --------
8. AGE: Years: About 77 Months: --- Days: --- If less than one day: --hr. -- min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Joseph M. Kelly
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary Anne Bishop
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Grace A. Ward
(b) Address: Rochambeau Apartments

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Meares and Son
(b) Address: 805 N. Calvert Street

19 (a) (Date received by Registrar) OCT 24 1946 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH OCTOBER 22 1946 at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 17 1946 to OCT 22 1946 and that I last saw her alive on OCT 22 1946

Immediate cause of death	Duration
CARCINOMIA OF SPLEEN. JANY. 17	1946
Due to METASTASIS OF LUNGS.	1946.
Due to	
Other Conditions NONE.	

(Include pregnancy within 3 months of death)
Date of operation NONE.
Major findings of operations: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. F. Blanton
Address 3013 ST PAUL STREET Date signed OCTOBER 22 1946.

1857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G41857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 229 N. Fremont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Fremont ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Wentworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Wentworth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Charles L. Wentworth
(b) Address 229 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 7000 Brantly ave

19 OCT 24 1946 Date of burial Huntington Williams Hall

MEDICAL CERTIFICATION 10/21/46 7:45 AM

20. DATE OF DEATH 10/21/46 19 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25/46 to 10/21/46 and that I last saw h[illegible] alive on 10/24/46

Immediate cause of death: Coronary thrombosis — Duration: 2 days

Due to: Angina pectoris

Due to: Organic heart lesions

Other Conditions: arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.

Address 524 Mark[illegible] Date signed 10/23/46

VS 150

1858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G41858

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 21-L South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111- Russell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 Months Days If less than one day hr. min.

9. Birthplace Howard County Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Unknown

13. Birthplace "

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Hollis Play

(b) Address 1629 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy DeWilson

(b) Address 1000 Broadway City

OCT 24 1946 (Date received by local registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1946, at 8.05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 10/22/46

VS 191

G44859 BC# 55619 — BALTIMORE CITY HEALTH DEPARTMENT — G44859

CERTIFICATE OF DEATH

119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30d.
(e) Length of stay in Baltimore (yrs., mos., or days) 53d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 S. Savage ST (If rural give location)
(e) Citizen of foreign country? Nat (Yes or No)
If yes, name country

3 (a) FULL NAME William Salahoris

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-46

8. AGE: Years	Months	Days	If less than one day
	1	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Salahoris
13. Birthplace Greece

MOTHER
14. Maiden Name Catherine Blatt
15. Birthplace W. Va.

16 (a) Informant Mother - Mrs. Salahoris
(b) Address 636 S. Savage St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-46 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Woodlawn

18 (a) Funeral director Lambros Funeral Inc.
(b) Address 431 E. North ave.

19 (a) (Date received by Registrar) (b)

OCT 24 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 22 1946, and that I last saw him alive on Oct 12 1946

	Duration
Immediate cause of death circulatory collapse	
Due to Toxemia	
Due to Infectious Diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James V. Minor, Jr. M. D.
Address Mercy Hospital Date signed 10/22/46

G44860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G44850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 439 Furrow Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 439 Furrow Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA B. NICODEMUS

3 (b) If veteran, name war ********
3 (c) Social Security Account No. ********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	widowed

6 (b) Name of husband or wife John W.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 11 -2- 1870

8. AGE: Years	Months	Days	If less than one day
75	11	19	******** hr. ******** min.

9. Birthplace Grafton, West Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace New York

16 (a) Informant Mrs. Ruth E. Dorsey
(b) Address 439 Furrow Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 24 Oct. 46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director W. B. Hilkert & Son
(b) Address 1300 Eutaw Place..17

19 (a) OCT 24 1946 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 October 1946 at 8:45 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1946 to 10/21 1946 and that I last saw h[illegible] alive on 10/18 1946

Immediate cause of death: Coronary Embolism

Duration 2 hrs

Due to: Coronary Sclerosis

Due to:

Other Conditions: Asthma Adhesions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Katzenberger M. D.
Address 721 Medical Arts Date signed 10/24/46

VS 190

Huntington Williams, M.D.

Dr. Katzenberger

G44861
CWK-104708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No. G44861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 72- 8- 23-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Cumberland Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Jacques

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30-1874

8. AGE: Years	Months	Days	If less than one day
72	8	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Jacques
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral
Location Baltimore Md.
18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1211 Druid Hill Ave.
19 (Date received by local registrar) OCT 24 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 23 1946, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26-1946 to Oct. 23 1946, and that I last saw h. im alive on Oct. 23 1946.

	Duration
Immediate cause of death Congestive heart failure	
Due to Arteriosclerotic cardio-vascular disease.	
Due to Calculus and pulpitis	
Other Conditions Benign prostatic hyperthrophy, Cystitis, Apelitis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. K. Gibbs
Address Baltimore City Hosp. Date signed 10/23/1946 M. D.

93D

G44862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G44862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Edmondson ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie E. Meister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Widowed

6 (b) Name of husband or wife unknown
Peter George Meister If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867-Aug 29

8. AGE: Years	Months	Days	If less than one day
79	1	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none (housewife)
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs. C. Fred Meister
(b) Address 2709 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Wintsle
(b) Address 401 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 24 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1946, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1946 to 10-22 1946, and that I last saw her alive on 10-22 1946.

Immediate cause of death	Duration
(a) Cardiac failure	
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions Congestive Failure + uterus cancer	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. F. McMorgan M. D.
Address Maryland Gen. Hosp. Date signed 22 Oct.

G44863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G44863
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 Old Battlegrove Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabel Delaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: George Delaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/12/74

8. AGE: Years	Months	Days	If less than one day
72	4	10	hr. min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dennis Shoemaker
13. Birthplace Frederick, Md

MOTHER
14. Maiden Name Harriet McKaye
15. Birthplace Ireland

16 (a) Informant George Delaney
(b) Address 224 Old Battlegrove Rd

17 (a) Burial (b) Date thereof 10/26/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd.

18 (a) Funeral director Henry J Connelly.
(b) Address 418 Eastern Ave. Edge 2 1

19 (a) (Date rec'd by registrar) (b) Registrar Williams

OCT 29 1946

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1946, at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3-1946, to 10-22-1946, and that I last saw h[illegible] alive on 10-22-1946.

Immediate cause of death	Duration
Myocardial Degeneration and failure	5 mo P.M.
Due to Coronary thrombosis	5 Do P.M.
Due to Arteriosclerosis	
Other Conditions Possible Cancer of Lung	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Franklin Sq Hosp Date signed 10/25/46

X

G44864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 106 C

G44864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road + Herring Run.
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day.
(e) Length of stay in Baltimore (yrs., mos., or days) 2days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural, Chase md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 15 (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Young

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 13, '23

8. AGE: Years	Months	Days	If less than one day
12	11	7	hr. min.

9. Birthplace Route 15, Baltimore Co. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Frederick W. Young
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Cecelia A Schuman
15. Birthplace Balto. Co. Md.

16 (a) Informant Cecilia Young
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/46 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run Rd.

18 (a) Funeral director John J Connelly.
(b) Address 418 Eastern ave.

19 (a) Oct. 22, 1946 (Date rec'd by registrar) (b) John J Connelly. Registrar

OCT 24 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-46 19 ..., at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1946, to 10-20 1946 and that I last saw him alive on 10-20 1946.

Immediate cause of death Respiratory failure.

Due to Laryngo tracheo bronchitis.

Due to

Other Conditions Cerebral birth injury & fracture.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address [signature] Date signed Oct 21, 46

X

G44865

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G44865

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Barrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Dixie Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE CLARKSON NOAKES BERRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Thomas Le Barry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1863

8. AGE: Years	Months	Days	If less than one day
83	7	14	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin T. Noakes
13. Birthplace England

MOTHER
14. Maiden Name -- Piper
15. Birthplace England

16 (a) Informant Mr. Thomas F. Berry, Jr.
(b) Address 12 Dixie Drive, Towson

17 (a) Burial (b) Date thereof 10/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) OCT 24 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Past year. to Oct 23 1946 and that I last saw her alive on Oct 23 1946

Immediate cause of death: Coronary Thrombosis — Duration 20 min.
Due to Angina Pect. — 5 yrs.
Due to Arteriosclerosis, — ✓
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 20 20 4, Charles Date signed 10/24/46

VS 190

44866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G44866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Baker St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS BENSON BOND

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 214-16-3299

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Jane Mays Bond
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) May 27, 1884

8. AGE: Years	Months	Days	If less than one day
62	4	25	hr. min.

9. Birthplace Cockeysville, Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self

FATHER
12. Name John Bond
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name May L. Benson
15. Birthplace Gambler, Carroll Co., Md

16 (a) Informant Mrs. Jane Mays Bond
(b) Address 3201 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory Jessups Cem.
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 24 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1946, at 2:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Oct 22 1946 and that I last saw him alive on Oct 21 1946

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions: Chronic cardio vas dis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. H. Cahen
Address 173 S. Pop & Dr Date signed 10/25/46 M. D.

VS 150

14867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G14867 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY AGNES ALGIE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Wm. Dailey Algie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1866

8. AGE: Years	Months	Days	If less than one day
80	0	5	hr. min.

9. Birthplace Burkhead, England (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name Wm. Mustgrave
13. Birthplace England

MOTHER
14. Maiden Name Alice Keller
15. Birthplace England

16 (a) Informant Mrs. Alice A. Haase
(b) Address 1822 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 24 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1946 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Oct. 22 1946 and that I last saw h[illegible] alive on Oct 22 1946.

Immediate cause of death: Intracerebral Hemorrhage — Duration: years

Due to: Chronic Glomerulonephritis — years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Lee Haase M. D.
Address 2 E. Preston St. Date signed 10/25/46.

VS 150

244868 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G44868
CERTIFICATE OF DEATH 186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden Sts.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Methodist Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Emma Robinson —

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F.
5. Color or race W.
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife THOMAS J. ROBINSON
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/28/1863
8. AGE: Years 83 Months 2 Days 26 If less than one day hr. min.
9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name JOHN [illegible] H. MIDDLEKAUFF
13. Birthplace MD
MOTHER 14. Maiden Name [illegible] CASSANDRA EVERETT
15. Birthplace MD.
16 (a) Informant
(b) Address
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Christian Location JOPPA MD
18 (a) Funeral director J. F. Reese
(b) Address WESTMINSTER
19 OCT 28 1946 (Date filed by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct. 27 1946, at 3:20 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 10-5-46 19 —, to 10-27-46 19 —, and that I last saw h[illegible] alive on 10-22-46 19 —
Immediate cause of death Cardiovascular failure and Terminal uremia — Duration
Due to Fractured neck of left femur, c
Due to
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation 10-7-46
Major findings of operation: As above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct. 5 46 at M
(c) Where did injury occur? Westminster Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell [illegible]
23. Signature Chris F. Angulo M.D. M. D.
Address Md Gen Hosp Date signed 10-24-46

VS 150 John R. Davis MD / per George B. Merrill MD X

G44869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G44869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 13
(e) Length of stay in Baltimore (yrs., mos., or days): 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 842 West 36th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Joeckel

3 (b) If veteran, name war: —

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Annie E Joeckel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-31-1868

8. AGE: Years: 77 | Months: 9 | Days: 22 23 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Gustave Joeckel
13. Birthplace Germany

MOTHER: 14. Maiden name Elizabeth Schluwacther
15. Birthplace Germany

16 (a) Informant: Mrs. Annie E Joeckel
(b) Address 842 West 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26-46 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Baltimore Md.

18 (a) Funeral director: Frank H Seitz
(b) Address 842 W 36th St

19 (a) OCT 24 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1946 at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1946 to 10-23 1946 and that I last saw him alive on 10-22 1946

Immediate cause of death: Cardiac Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-15-46

Major findings of operation: Incarcerated omentum in left inguinal hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: R. E. Hampton M.D.
Address Md. Gen. Hosp. Date signed 10-28-46

VS 150

24870 Colored

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ C24870 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 N. Duncan
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 67yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Duncan St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Housek Housek

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Joseph A. Housek
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 12, 1879

8. AGE: Years 67 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Prague Bohemia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Liha
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Joseph Housek
(b) Address 402 N. Duncan

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Balto Md
18 (a) Funeral director Lynch & Brockway
(b) Address 900 N. Chester St

(a) 21 1946 (Date rec'd by registrar) (b) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946, at Home

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 22 1946.
and that I last saw h[illegible] alive on Oct 22 1946

Immediate cause of death: Pulmonary Edema — Duration 10/19/46
Due to Chr. Myocard. D.S — 10/1/46
Due to Diabetes Mellitus — 10/1/46
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William L. Brown M.D.
Address 501 N Kenwood Ave Date signed 10/23/46

VS 150

4871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

✓ G-4871 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 N Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N Bluxton St.
(If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Levy.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	married.

6 (b) Name of husband or wife Emma Levy.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/82.

8. AGE: Years	Months	Days	If less than one day
63 64.	11	29	hr. min.

9. Birthplace Baltimore (State, county, and state)
10. Usual Occupation Tailor.
11. Industry or business

FATHER
12. Name James Levy
13. Birthplace Bohemia

MOTHER
14. Maiden Name Sophie Kramer
15. Birthplace Bohemia

16 (a) Informant Emma Levy
(b) Address 912 N. Eberton St

17 (a) buried (Burial, cremation, or removal) (b) Date thereof 10-25-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Broccolo
(b) Address 900 N Eberton St

19 (a) 11-1-1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/1946, at 11 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21/1946 to 10/21/1946 and that I last saw h[illegible] alive on 10/21/1946.

Immediate cause of death: Cardio respiratory failure. — Duration

Due to Cardiac Decompensation

Due to Coronary occlusion.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Levy M.D.
Address St. Joseph Hosp. Date signed 10/22/46

VS 150

044872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 C

044872 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Lakeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Seymour M. Hecht (SEYMOUR-M-HECHT)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-82

8. AGE: Years	Months	Days	If less than one day
64	8	17	hr. X min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Retired

FATHER
12. Name Myer S. Hecht
13. Birthplace Maryland

MOTHER
14. Maiden Name Betty Meyer
15. Birthplace Maryland

16 (a) Informant relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Har Sinai Cem
Location Erdman Ave
18 (a) Funeral director J. Ahrens Co
(b) Address 340 W. Read St
19. (a) OCT 24 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1946 at 2 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1946, to 10-23 1946, and that I last saw him alive on 10-23 1946.

Immediate cause of death	Duration
Carcinoma of Stomach	
Due to Extension to liver	
Due to Metastases to peri-aortic lymph nodes	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy (Above)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature A. M. Knight M. D.
Address Date signed

VS 150

44873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G44873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3028 Clifton Park Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] 3028 Clifton Pk Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Allen Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Brown
6 (c) If alive, give age 187 years

7. Birth date of deceased (mo., day, yr.) 11-23-(1872)

8. AGE: Years 74 | Months 11 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Decorator
11. Industry or business

FATHER
12. Name George A. Brown
13. Birthplace Md

MOTHER
14. Maiden Name Julia N. Taylor
15. Birthplace Md

16 (a) Informant Mrs Annie Mary Brown
(b) Address 3028 Clifton Park Terrace

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Kendall E Humphreys
(b) Address 6067 Harford Rd

19 (a) [redacted] (b) Huntington Williams, M.D.
Address DCT 24 1946

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946, to Oct 23 1946, and that I last saw h. alive on Oct 23 1946

Immediate cause of death: Intestinal Obstruction — Duration
Due to: Carcinoma of Sigmoid
Due to:
Other Conditions: Arteriosclerosis, Hypertension, Myocarditis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin A. Anderson M. D.
Address 3001 Shannon Drive Date signed Oct-24-46

G44874 BALTIMORE CITY HEALTH DEPARTMENT G44874
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4982 Denmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4982 Denmore Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Grace Darling Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Early Hyter Johnson Sr.
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) December 2 1886

8. AGE: Years 60 | Months 10 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Accomac Co. Virginia (Town, county and state)
10. Usual Occupation house-wife
11. Industry or business —

FATHER 12. Name George Wilder Kellam
13. Birthplace Virginia

MOTHER 14. Maiden Name Tibatha Custis
15. Birthplace Virginia

16 (a) Informant Early Hyter Johnson, Sr.
(b) Address 4982 Denmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-46 (month) (day) (year)
(c) Cemetery or crematory Bella Haven
Location Accomac Co Va.

18 (a) Funeral director Loring Byers
(b) Address 5005 Pk Heights Ave.

19 (a) OCT 24 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22- 1946, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 15 1946, to 10-22- 1946, and that I last saw h.e alive on 10-21- 1946.

Immediate cause of death: Coronary Thrombosis — Duration a few months

Due to

Due to

Other Conditions Nevritis — 9 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 10-24-46

VS 180

G44875 ✓ G44875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha J. Beach.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Leonard E Beach Md (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1875

8. AGE:	Years	Months	Days	If less than one day
	71	3	19	hr. min.

9. Birthplace Madison New York (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name James Phillips
13. Birthplace Wales

MOTHER
14. Maiden Name Lydia Jones
15. Birthplace Wales

16 (a) Informant George Beach
(b) Address 2229 St Paul St

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Stockton St. Cem.
Location Stockwell New York

18 (a) Funeral director Lowry Curtis
(b) Address 5005 York Heights Ave

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 24 1946 H. Vaughn Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 October 1946, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Oct. 1946 to Oct 23 1946 and that I last saw h er alive on Oct 22 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S.C. Proctor M.D.

Address 1123 St. Paul St. Date signed 23 Oct 46 M. D.

X

G44876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G44876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 Brentwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Brentwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Foerster

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) ~~Single, married,~~ widowed, or divorced.

6 (b) Name of husband or wife Charles Foerster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 - 1862

8. AGE: Years 83 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Mrs Hardesty
(b) Address 1903 Brentwood Ave

17 (a) Burial (b) Date thereof 10/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edw Lowman
(b) Address 2307 Arlington Blvd

19 (a) (b)
(Date rec'd by registrar)

OCT 24 1946

Funeral from Williams Mill

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23. 1946. at 8-P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1946. to Oct 23 1946. and that I last saw h.er alive on Oct 23 1946.

Immediate cause of death	Duration
(a) Pneumonia	mos
Due to (b) Cardio vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ger. J. McKeffer M. D.

Address 2470 Mark Blvd Date signed Oct 24 46

G44877 G44877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43B

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write Rural, and give town)
(d) Street No. 1902 N. Castle Street
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Harry McCready

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex Male | 5. Color or race Colored | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of ~~husband~~ or wife Mildred

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 10th 1896

8. AGE: Years 50 | Months 4 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name John W. McCready

13. Birthplace Va.

MOTHER

14. Maiden Name Sally E. Crockett

15. Birthplace Va.

16 (a) Informant Mrs Mildred McCready

(b) Address 1902 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26th 1946 (month) (day) (year)

(c) Cemetery ~~or crematory~~ National

Location Frederick Road

18 (a) Funeral director Leo S. Cook

(b) Address 1703 N Patterson Park Ave

19 (a) ..... (b) .....
(Date received by registrar) Registrar

VS 191

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 23, 1946, at 10 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Left cerebral thrombosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 10/27/46

G44878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G44878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Dupree

3 (b) If veteran, name war

3 (c) Social Security Account No. 246-12-5382

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lydia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6th 1904

8. AGE: Years	Months	Days	If less than one day
42	2	17	hr. min.

9. Birthplace N. S.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Mutual Insurance Co

FATHER
12. Name John W. Dupree
13. Birthplace N. S.

MOTHER
14. Maiden Name Lula Barber
15. Birthplace N. S.

16 (a) Informant Mrs. Lydia Dupree
(b) Address 804 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26th 1946 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md

18 (a) Funeral director Leo F. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) OCT 24 - (Date rec'd by registrar) (b) Burlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1946, at 6.20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/24/46

VS 191

14879

CHK-105509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. G44879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 41- 1- 23-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Patapsco Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman C. Carper

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9611

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30-1905

8. AGE: Years 41 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Oakland, Maryland (Town, county, or state)

10. Usual Occupation Chauffeur (Truck)

11. Industry or business Elliott Machine Corp

FATHER: 12. Name William Carper
13. Birthplace Martinsburg West Virginia

MOTHER: 14. Maiden Name Carrie Miller
15. Birthplace Martinsburg West Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT. 26 1946 (Month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Balto., Md.

18 (a) Funeral director A. Edward Evans
(b) Address 1005 S. Charles St., Balto. 30, Md.

19 Date received OCT 24 1946 Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 23 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946 to Oct. 23 1946 and that I last saw h. 1m alive on Oct. 23 1946.

Immediate cause of death: Myocardial failure — Duration

Due to Arteriosclerotic Cardiac sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Negative Reason for Autopsy Industrial Accident

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Walker M. D.
Address B. C. H. Date signed 10/25/46

X

G44880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 927

G44880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland ? County Baltimore
(c) City or town Randallstown (If outside city or town limits, write RURAL and give town)
(d) Street No. ? Liberty Road. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Worthington Young
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mrs. Howard W. Young
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) June 19, 1881
8. AGE: Years 65 Months 5 Days 4 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Tavern keeper
11. Industry or business

FATHER
12. Name William H. Young
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Gertrude Bush
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md

18 (a) Funeral director C. Harry Lewis
(b) Address Sykesville, Md.

OCT 24 1946 (b) (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1946, at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1946, to Oct. 24 1946, and that I last saw him alive on Oct. 24 1946

Immediate cause of death	Duration
Cardiac Decompensation	1 mth
Due to Arteriosclerotic Heart Disease	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address V. M. H. Date signed Oct 25 1946

G44881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G44881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 N. Collington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1881

8. AGE: Years	Months	Days	If less than one day
65	7	24	hr. min.

9. Birthplace ? Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary J. Upton
15. Birthplace Washington D.C.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

OCT 24 1946 (b) Huntington Williams Mt
(Date received by local registrar) (1946)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1946, to Oct. 22 1946, and that I last saw him alive on Oct. 22 1946.

Immediate cause of death: Malnutrition — Duration 6 mos.
Due to Chronic Alcoholism
Due to
Other Conditions Pulmonary Tbc, moderately or Far Advanced
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 10-22-46

VS 150

X

G44882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1118

Registered No. G44882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 N Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie M. Wetz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1930

8. AGE: Years 16 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation assembly line

11. Industry or business Venetian Blind Co.

FATHER
12. Name Charles
13. Birthplace Baltimore

MOTHER
14. Maiden Name May Gordon
15. Birthplace England

16 (a) Informant Mrs. May Metz
(b) Address 1828 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) OCT 24 1946 (Date rec'd by registrar) (b) Huntington Hollins M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1946, at 6.20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/22/46

VS 191

G44883 BALTIMORE CITY HEALTH DEPARTMENT G44883

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1067 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Horsey

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife Carrie Horsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1903

8. AGE: Years	Months	Days	If less than one day: hr. min.
43	2	12	

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name Albert Horsey
13. Birthplace Md.?

14. Maiden Name Ella
15. Birthplace Md.

16 (a) Informant Carrie Horsey
(b) Address 1067 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Lexington St.

19 (a) Oct 24 1946 (Date received by registrar) (b) Funeral Director for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1946 at 1 25/60 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to

Other Conditions History of epilepsy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-21-46 at 1:15 P.M. 1/4
(b) Where did injury occur? Hudson & Baxter Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell from "junk" wagon

23. Signature George G. Morrill M.D.
Medical Examiner.
Date signed 10/24/46

475

VS 161

G44881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 164 c

G44881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 Walbrook Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH VIRGINIA RIAL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Ireton Rial

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 6, 1914

8. AGE: Years 32 | Months 3 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace: St. Mary's Co., Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

Mother

12. Name: William P. Thompson

13. Birthplace: Md.

Father

14. Maiden Name: Mary Goldsborough

15. Birthplace: St. Mary's Co., Md.

16 (a) Informant: Mr. Joseph I. Rial

(b) Address: 2114 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) OCT 24 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1946, at 5:38 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-22-46 at 4:20 P. M.

(b) Where did injury occur? 2114 Walbrook Avenue

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Firearms

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 10-23-46

VS 191

44885

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

G44885 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. Prospect Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY FRANCIS CROUCH

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	215-09-6054	Male	White	Married

6 (b) Name of husband or wife Ella Frame Crouch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1899

8. AGE: Years	Months	Days	If less than one day
46	10	0	hr. min.

9. Birthplace Maryland (Balto.) (Town, county, and state)
10. Usual Occupation Purchasing Agt.
11. Industry or business National Can Co.

FATHER
12. Name Francis Perkins Crouch
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Clara Agnes Little
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Ruth Frame Crouch
(b) Address 30 N. Prospect Ave., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 24 1946 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1946, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Accident Baltimore.
Due to: Cardiac Dilitation
Due to: Hypertension
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil Von Smith Swain M.D. M. D.
Address St. Agnes Hosp. Date signed 10/24/46

VS 150

G44886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G44886 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-n
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Tudor Arms Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Catherine Kohler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mr. Henry Kohler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1909

8. AGE: Years	Months	Days	If less than one day
37	6	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Balto.

MOTHER
14. Maiden Name Maude Hoffman
15. Birthplace Balto.

16 (a) Informant Dr. M. Henry Kohler
(b) Address 3714 Tudor Arms Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 24 1946 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1946, at 9:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/23/46 ? P. M.
(b) Where did injury occur? Home - 3714 Tudor Arms
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down stairs at home

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/24/46

VS 181

G44887 BCH F21556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

115c

G44887 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Mayfield Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrea Marian Nickol

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife /
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1941

8. AGE: Years	Months	Days	If less than one day
5	9	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Andrew G. Nickol
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marion Debes
15. Birthplace Baltimore Md

16 (a) Informant Mr. Andrew Nickol
(b) Address 3020 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b)
Registrar

OCT 24 1946
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22-1946 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22-1946 to 10-22-1946 and that I last saw him alive on 10-22-1946.

Immediate cause of death Cardio-Resp Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation / Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence J. Knop M. D.
Address Date signed

X

G44888

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 937

G44888

Reg. Dist. No. _____

PLACE OF DEATH: 2648 Harlem Ave

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

...to above place of death? _____

...institution, or street address where death occurred: 16-6

...to hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2648 Harlem Ave

(If rural, give LOCATION)

2.(a) If veteran, name war _____

FULL NAME John S. Sturgeon

3. (b) Social Security Number 212-01-3874

...le | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: married

...me of husband or wife: Edna C. Barger

6.(c) If wife, give age: 64 years

...date of ...rth (mo., day, yr.): May 15th 1881

AGE: Years: 65 | Months: 5 | Days: 7 | If less than one day: ____ hrs. ____ min.

...place: Maryland (City, county, and state)

...al occupation: Burger

...stry or business: Hotel Equipment

...Name: John T. Sturgeon

...Birthplace: Unknown

...Maiden name: Jean Murdock

...Birthplace: Unknown

...rmant: Mrs Edna C. Sturgeon

...ess: 2648 Harlem Ave

...Burial ... Date thereof: 10/26/46 (month) (day) (year)

...tal, cremation, or removal. Which?)

...tery or crematory: Loudon Park

...ss: Frederick Avenue

...ral director: John F Denny Inc

...ess: 711 Light St.

OCT 24 1946 Huntington Williams, M.D. Registrar

...ate rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22nd 1946, at 8 o'clock P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1943 to Oct 22 1946 and that I last saw h.../he... alive on Oct 22 1946

Immediate cause of death: Intermediate Heart Disease — DURATION

Due to _____

Due to _____

Other conditions Bronchiectasis

(Include pregnancy within 3 months of death)

Major findings of operation _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Albert J Thurlow M.D.

M. D. or other

Address 2302 Edmondson Ave Date signed 10/24/46

14883 Grave #13 - Found Pier 4 - Pratt St side

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1883 Not registered No. G14889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pier 1 Pratt St
(c) Hospital or institution: 700 - Fleet St - City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown White-Male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 48? Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

MOTHER / FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY OCT 24 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 24 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. -6 1946, at 9:15 A M

21. I certify that I took charge of the remains described above, held an Partial Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ? at ? 4/1 M.

(b) Where did injury occur Pier 1 - Pratt St - Pier

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Drowned

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 10/7/46

473

G44890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G41890 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2607 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. Kenwood Ave & Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Wilhelmina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5th 1873

8. AGE: Years	Months	Days	If less than one day
73	7	18	hr. min.

9. Birthplace Aurora, Ind. (Town, county, and state)
10. Usual Occupation Unemployed Carpenter
11. Industry or business Building

FATHER
12. Name Henry Walker
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John C. Walker
(b) Address 251 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. - Extended

18 (a) Funeral director Wilkinson Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Huntington Williams, M.D. (b) Registrar
Date rec'd by registrar OCT 27 1946

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1946 at 2.50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Ruptured aneurysm of aorta with hemorrhage into pericardial cavity.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/24/46

G44891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44891 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2939 Mills Avenue
(c) Hospital or institution:
Home 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2939 Milles Avenue
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Renny Shehan

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rosa Ayars Shehan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown 1874

8. AGE: Years	Months	Days	If less than one day
71	10	12	hr. min.

9. Birthplace unknown (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Shehan
13. Birthplace unknown

MOTHER
14. Maiden Name Elizabeth Bennet
15. Birthplace unknown

16 (a) Informant Mrs. Rosa Ayars Shehan
(b) Address 2939 Miles Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 24 1946; and that I last saw h. alive on Oct 22 1946

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Edw. P. Glassman M. D.
Address 2037 Eutaw Pl. Date signed 10/24/46

VS 150

Edw. P. Glassman

G44892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162H

Registered No. G44892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-6
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2634- Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara B. McIlenny (McIlhenny)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Marshall McIlhenny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1861

8. AGE: Years	Months	Days	If less than one day
84	10	21	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business: Self

FATHER
12. Name: Rev. Geo. J. Zimmerman
13. Birthplace: Frederick Md.

MOTHER
14. Maiden Name: Mary E. McCahey
15. Birthplace: Md.

16 (a) Informant: Mrs. James L. Moran
(b) Address: 913 Hale Thorpe Ave - Hale Thorpe Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 917 St. Paul St.

19 (a) (Date rec'd by registrar) OCT 25 1946 (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION p.

20. DATE OF DEATH Oct. 23, 1946, at 1.40 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carbon Monoxide poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/23/46 at apprx 12 P. M.
(b) Where did injury occur? Home - 2634 - Harlem Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Unlt. gas poisoning

23. Signature Geo. L. Merrill M.D. Medical Examiner.
Date signed 10/24/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44893 Registered No.

G44893 1107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 153 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home. N Broadway.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Irene L Gogel

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Mr. — Gogel.
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Apr 16, 1856
8. AGE: Years 90 | Months 6 | Days 7 | If less than one day: hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business Home duties

FATHER
12. Name Thomas Simmons
13. Birthplace Maryland.

MOTHER
14. Maiden Name Isabel Woodyard.
15. Birthplace Md.

16 (a) Informant Mrs Susanne Gogel.
(b) Address 613 Riverview Ave Balto 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1 W Saratoga St. St. Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 25 1946
Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23, 1946, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946 to Oct 23 1946 and that I last saw h[illegible] alive on Oct 23 1946

Immediate cause of death: Bronchopneumonia, bilateral — Duration: 7 days
Due to:
Due to: Bronchiectasis, bilateral, chronic — 20 yrs.
Other Conditions: Arteriosclerosis, general. — 10 yrs.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Autopsy: Bronchopneumonia, bilateral.
of autopsy: arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Bachrach M. D.
Address Church Home + Hosp. Date signed Oct 27 46

VS 180

G44894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G44894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 N. Eutaw St
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren W. Du Pre

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Du Pre
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23rd 1883

8. AGE: Years	Months	Days	If less than one day
63	1	0	hr. min.

9. Birthplace Charlottesville Va. (Town, county and state)
10. Usual Occupation Retired Salesman
11. Industry or business Gas + Electric Co.

FATHER
12. Name Marshall M. Du Pre
13. Birthplace S.C.

MOTHER
14. Maiden Name Anna L. Thompson
15. Birthplace Va.

16 (a) Informant Anna Du Pre
(b) Address 1108 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 25 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23rd 1946, at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Oct 23 1946 and that I last saw h[illegible] alive on Oct 23 1946.

Immediate cause of death	Duration
Carcinoma of Stomach	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W Fayette St Date signed Oct 27 1946

VS 150

G44895 BCH G62770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓64

G44895
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~St.~~ 205
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508- S. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William O'Brien KNIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2- 1946

8. AGE: Years 0 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raff L. Knight
13. Birthplace Chestertown Md

MOTHER
14. Maiden Name Frances A. Manka
15. Birthplace Baltimore Md

16 (a) Informant Raff L. Knight
(b) Address 508 S. Bentalou St

17 (a) Burial (b) Date thereof Oct 26-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Pauls M.E. Church
Location Granite Md

18 (a) Funeral director Raff & B.M. Walter
(b) Address Pratt & Fulton Sts

19 (a) (b)
(Date received by registrar) Registrar

OCT 25 1946

VS 181

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1946, at 11.15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymico lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10/24/46

G44896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44896 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2524 Loyola Southway
(c) Hospital or institution: 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 Loyola Southway (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Bella Pierce (Piefsky)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19, 1888

8. AGE: Years 57 58 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Benjamin Rubman

13. Birthplace Russia

14. Maiden Name Hannah

15. Birthplace Russia

16 (a) Informant Mrs Bernard Caplan

(b) Address 2524 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Hampton Ave + Philadelphia Rd

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Balto St

19 (a) OCT 25 1946 (b) Huntington Williams (Clerk for City Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1946, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 1ST 1945 to OCT 24 1946 and that I last saw her alive on OCT 23 1946.

Immediate cause of death	Duration
Hypertension Cardiovascular	Few yrs
Due to Cerebral Hemorrhage	1 Day
Due to Respiratory Failure	24 hrs
Other Conditions Obesity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex A Weinstock M.D.

Address 4603 Old Harford Date signed 10/24/46

VS 150

HEALTH DEPARTMENT—CITY OF BALTIMORE

644897 644897

CERTIFICATE OF DEATH 1830

1. PLACE OF DEATH 27-17

CITY OF BALTIMORE: (No. 5104 WOLVERTON Ave Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 68 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME BARNETT SHUGAM

If U. S. Veteran specify WAR

(a) Residence: No. 5104 WOLVERTON Ave Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

6a. If married, widowed or divorced HUSBAND of (or) WIFE of Jennie

6. DATE OF BIRTH (month, day, year) 1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Russia

FATHER

13. NAME Jacob

14. BIRTHPLACE (city or town) (State or country) Russia

MOTHER

15. MAIDEN NAME Rachael

16. BIRTHPLACE (city or town) (State or country) Russia

17. INFORMANT Ida Shugam

(Address) 5104 Wolverton Ave

18. BURIAL, CREMATION, REMOVAL

Place Rosedale Date 10/25 19X6

19. UNDERTAKER Jack Lewis Sons

(Address) 1439 E Baltimore St

20. FILED 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct. 25 1946

22. I HEREBY CERTIFY, That I attended deceased from 7 Oct. 1946 to 23 Oct. 1946

I last saw h.[illegible] alive on 23 Oct. 1946 Death is said to have occurred on the date stated above, at 2.30 A m.

The principal cause of death and related causes of importance were as follows:

	Duration of disease
ARTERIOSCLEROSIS, GENERALIZED	1931
CEREBRAL HEMORRHAGE	1937
CEREBRAL HEMORRHAGE	Oct. 6/46

Other contributory causes of importance

Was an operation performed? NO Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signed) Benjamin Highstein M. D.

(Address) 121 S. HIGHLAND AVE.

OCT 25 1946 Huntington Williams, M.D.

G44898 BALTIMORE CITY HEALTH DEPARTMENT G44898

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH: 10-1
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw St.
(c) Hospital or institution: Elsinore Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeannette E. Byrnes

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hugh Byrnes

6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 8 1873

8. AGE: Years 73 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: House work at Home

11. Industry or business:

FATHER
12. Name: James Noakes
13. Birthplace: Sulphur Spring W. Va

MOTHER
14. Maiden Name: Ellen Britton
15. Birthplace: Charlestown W. Va

16 (a) Informant: Edward Christian
(b) Address: Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 28/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Co. Location: East Side of Pulaski Hwy

18 (a) Funeral director: Edwin W. Conklin Sons
(b) Address: 924 E. Eager St.

19 (a) Date received by registrar: OCT 25 1946 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24, 1946, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1946 to 10/23 1946 and that I last saw h W alive on Oct 23 1946.

Immediate cause of death: Acute Congestive Pneumonia — Duration:
Due to: Acute cardiac failure
Due to: Ch myocarditis
Other Conditions: Generalized Sclerosis.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Ab Hornstein
Address: 733 Aisquith St Date signed: M. 10 D. 24/46

PHYSICIAN: Underline the cause to which death should be charged statistically.

G44899 | BALTIMORE CITY HEALTH DEPARTMENT | G44899 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3712 Chesholm Road,
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Chesholm Road,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert H. Bushby,

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Genevieve Bushby,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	3	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Construction Engineer
11. Industry or business Amusement Park

FATHER
12. Name James Haven Bushby,
13. Birthplace England,

MOTHER
14. Maiden Name Karterine Constable,
15. Birthplace Virginia,

16 (a) Informant Mrs. L. Genevieve Bushby,
(b) Address 3712 Chesholm Road,

17 (a) burial (b) Date thereof 10/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director La Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 25 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1946, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to 10/23 1946, and that I last saw h[illegible] alive on 10/23 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 8 Days
Due to: Arterio sclerosis, Hypertensive Cardio Vascular Disease — 10 Yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Zuerlein M. D.
Address 2318 Eutaw Place Date signed 8/30/46

G44900 — BALTIMORE CITY HEALTH DEPARTMENT — G44900 Registered No.

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 64
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Rode

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Henry E. Rode
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20 1895

8. AGE: Years	Months	Days	If less than one day
50	10	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

PARENTS
12. Name Samuel Davis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ort Snow
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) (Date rec'd by registrar) (b)

OCT 25 1946 Huntington Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dead on arrival 19 to 19, and that I last saw h alive on 19

Immediate cause of death H emorrhage — Duration

Due to Carcinoma uterus (cervix)

Due to

Other Conditions Old Ca case, 1 op 1 op 3 yrs, came in moribund (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place) While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund R. Novak M. D.
Address Johns Hopkins Date signed Oct 2

X

G44901 G44901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 N. Broadway
(c) Hospital or institution: 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada C. Erck

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1891

8. AGE: Years	Months	Days	If less than one day
55	7	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Charles Erck
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Walz
15. Birthplace Maryland

16 (a) Informant Miss Helen Erck
(b) Address 602 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2006 Orleans St.,

19 (a) OCT 27 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1946 at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 9, 1945 to October 23, 1946 and that I last saw deceased alive on October 23, 1946.

Immediate cause of death	Duration
Cardiac Dilatation	5 days
Due to Aortic Insufficiency and Arterial Hypertension	4½ yrs 4½ yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg M. D.
Address 2052 North Ave Date signed 10-27-46

Huntington Williams, M.D.

X

44902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G44902 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Wildwood Pkwy.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Wildwood Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB HOWARD NAILL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred S. Naill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1878

8. AGE: Years 68 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Trainman

11. Industry or business B. & O. R. R.

FATHER
12. Name John Graybill Naill
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ellen Miller
15. Birthplace Maryland

16 (a) Informant Mrs. Mildred S. Naill wife
(b) Address 600 Wildwood Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Keedysville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 25 1946 (Date received by registrar) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1946 at 852 [illegible]

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Sept. 1946 to 23 Oct. 1946. and that I last saw h. im alive on 23 Oct. 1946

Immediate cause of death: Carcinoma of Colon — Duration: 6-Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 1946

Major findings of operation: Inoperable carcinoma of colon.

of autopsy: None done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide --
(b) Date of occurrence -- at M
(c) Where did injury occur? --
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward F. Milan, M.D.
Address Edward F. Milan, 682 Wash. Blvd., Balto., Md. Date signed 24 Oct

VS 130

Dr. Krumrein
726 Haywood

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44903
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 Homestead Street
(c) Hospital or institution:

9-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Homestead Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Pawn Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Richard M. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1886

8. AGE: Years	Months	Days	If less than one day
59	10	26	hr. min.

9. Birthplace Denton, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Samuel Pawn
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Richard M. Baker
(b) Address 1720 Homestead Street

17 (a) Burial (b) Date thereof 10/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by registrar)

Huntington Williams Supt.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24th, 1946 at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Oct 24 1946 and that I last saw her alive on Oct 22 1946

Immediate cause of death
Coronary Thrombosis
Cardio-Vascular-Hypertensive Dis
Due to arterio-sclerosis -
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

Duration
Oct 24/46
1 day
1 Year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed

X Oct 24 46

G44904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 E. 27th St.
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E 27th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ethel V. Seitz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pleasant Seitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/88

8. AGE: Years 58 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Thomas E. Callahan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Virginia Colbert
15. Birthplace Balto. Md.

16 (a) Informant Mr. P. R. Seitz
(b) Address 333 E 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Langdon Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (b) Registrar

Date Received OCT 25 1946 Lexington Hillcrest, M.F.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23rd 1946, at 3.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4, 1944 to Oct. 23, 1946, and that I last saw her alive on Oct. 23, 1946.

Immediate cause of death	Duration
Cerebral apoplexy or Cerebral Hemorrhage	1 week.
Due to Hypertension & cerebral arterio-sclerosis	2 years
Due to	
Other Conditions Diabetes	5 years.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ ✓ ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Frank M. Ogden M. D.

Address 2701 N. Calvert St. Date signed Oct. 24, 46

P.3a

G44905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

Registered No. G44905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~777 W. Le~~ 4-2
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 777 W. Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	M

6 (b) Name of husband or wife Lulabelle Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1920

8. AGE: Years	Months	Days	If less than one day
26 25	-	7	hr. min.

9. Birthplace Holly Hill S. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name David Taylor
13. Birthplace Holly Hill S.C.

MOTHER
14. Maiden Name Frances Small
15. Birthplace Holly Hill S.C.

16 (a) Informant Mistress Campbell
(b) Address 810 N. Stricker St.

17 (a) Shipped (b) Date thereof Oct. 25, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Creston S.C.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Registrar
(Date received by registrar)
OCT 25 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1946, at 1:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1946 to 10/22 1946, and that I last saw him alive on 10/22 1946.

Immediate cause of death

	Duration
Massive Intracerebral Hemorrhage	2 hr.
Due to Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C. Manson M. D.
Address 2 Univ. Hosp. Date signed 10/22/46

X

G44906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-1
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Archie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1896

8. AGE: Years 50 | Months 9 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Alice Burke
15. Birthplace Va.

16 (a) Informant Archie Holland
(b) Address 619 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A 9 County Md

18 (a) Funeral director Mrs. Cath. A Elliott Dft.
(b) Address 1129 N. Caroline St

19 (a) (Signature of undertaker or agent) (b) Huntington Williams Undertaker

OCT 25 1946
VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/46 19 , at 9 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Williams M.D.
Medical Examiner.
Date signed 10/28/46

G44907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44907 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 325 W. 106th Street
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Semih Temel

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
	none	Male	White	Married

6 (b) Name of husband or wife Elizabeth(Mohay)Temel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1898

8. AGE: Years	Months	Days	If less than one day
48	0	18	hr. min.

9. Birthplace Turkey (Town, county, and state)
10. Usual Occupation Exporter
11. Industry or business Gen'l. Merchandise

FATHER
12. Name Rustem Temel
13. Birthplace Turkey

MOTHER
14. Maiden Name Seniye Hanim
15. Birthplace Turkey

16 (a) Informant Frank E. Campbell Fun'l. Home
(b) Address 1076 Madison Ave., New York, N.Y.

17 (a) Burial-Removal (Burial, cremation, or removal) (b) Date thereof 10/25/46 (month) (day) (year)
(c) Cemetery or crematory Ferncliff Cem.
Location Ardsley, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams Mfr
OCT 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1946, at 10.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Coronary Artery disease
Pulmonary edema
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/24/46

G44908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G44908 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert 123
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 446 E. 28th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mollie Talbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife. Leon A. Talbott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1865

8. AGE: Years 81 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Pittsburgh, Pa (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name — Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Hanna Von Mispelhorn
15. Birthplace Germany

16 (a) Informant Mrs Virginia Kirsch
(b) Address 5701 Stuart Ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Sullivan Mortuary Co.
(b) Address 108 W Madison St.

19 (a) OCT 25 1946 (Date received by registrar) (b) Huntington Hollins, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1946, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1946, to 10-24 1946, and that I last saw h er alive on 10-24 1946

Immediate cause of death Bilateral toxicity — Duration

Due to Gangrene of left arm — 6 days

Due to Embolus of left brachial artery — 6 days

Other Conditions AS HD — yrs

(Include pregnancy within 3 months of death)

Date of operation 10-23-46

Major findings of operation: Gangrene of left arm caused by embolus

of autopsy Pre-mortem impressions

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford M. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp Date signed 10-24-46

VS 150

X

G44909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G44909 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bellona Ave & Belvedere
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Stoneleigh (If outside city or town limits, write RURAL, and give town)
(d) Street No. 6909 Stoneleigh Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Stanley Wells

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Wm. L. Wells
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Sept 6 1863
8. AGE: Years 84 | Months 1 | Days 7 | If less than one day: hr. min.
9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name Richard Stanley
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Elizabeth Cain
15. Birthplace Harford Co. Md.

16 (a) Informant Mr. Wm. L. Wells, Jr. (son)
(b) Address Stoneleigh - Baltimore
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 46 (month, day, year)
(c) Cemetery or crematory New Cathedral
Location Baltimore.
18 (a) Funeral director Stewart Marzella
(b) Address 1818 N Eutaw St.
19 OCT 25 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 October 1946, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Jan 1946 to 23 Oct 1946, and that I last saw h.. alive on 22 Oct 1946.

Immediate cause of death	Duration
myocarditis chronic	2 years
Due to hypertension	10 years
Due to arteriosclerosis	20 years
Other Conditions colitis, chr	1 year

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Randall L. Smith, Jr. M. D.
Address 1614 St Paul St Date signed 23 Oct 46

VS 150

G44910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G44910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 Edgevale Rd
(c) Hospital or institution: at home 27-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Edgevale Rd (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Charlotte Plant

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	none	Female	White	Widow

6 (b) Name of husband or wife Geo. S. Plant
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 29 1857

8. AGE: Years	Months	Days	If less than one day
88	9	25	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles Sloman
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Louise Heider
15. Birthplace Washington D.C.

16 (a) Informant Mrs Lillian L Cox daughter
(b) Address 500 Edgevale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory Rockcreek
Location Washington D.C.

18 (a) Funeral director Student Mortuary
(b) Address 108 W North Ave.

19 OCT 25 1948 Huntington Hillman, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1941 to Oct 24 1946 and that I last saw h-er alive on Oct 24 1946.

Immediate cause of death
(a) Myocarditis
Antecedent Cerebral Hemorrhage
Due to Hypertension

Duration
Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H Haady M.D.
Address 1403 Park Ave Date signed 10/25/46

VS 180

1911

BALTIMORE CITY HEALTH DEPARTMENT ✓ G41911

CERTIFICATE OF DEATH 44B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2593 W. Baltimore St.,
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68-4-14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2593 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gibson

3 (b) If veteran, name war: --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence L. Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1878

8. AGE: Years	Months	Days	If less than one day
68	4	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary N. Coolahan
15. Birthplace Md.

16 (a) Informant Mrs. Florence L. Gibson
(b) Address 2593 W. Baltimore St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

(c) Filed OCT 25 1946 (d) Signature of Registrar Williams M.D.

VS 150

MEDICAL CERTIFICATION 11.55

20. DATE OF DEATH October 23, 1946 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1943 to Oct 23 1946 and that I last saw him alive on Oct 23 1946.

Immediate cause of death — Duration

Due to Heart failure
due to aortic regurgitation

Due to Hodgkins disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Robinson M. D.
Address 203 Dolphin St Date signed 10/25/46

X

1912

BALTIMORE CITY HEALTH DEPARTMENT ✓ G41912

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1470 William St.
(c) Hospital or institution: 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1470 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche A. Koch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife August Koch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1867

8. AGE: Years	Months	Days	If less than one day
78	9	25	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name George H. Hiss
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Weaver
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1470 William St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director James L. McCarthy
(b) Address 130 E. Fort Ave.

19 (a) OCT 25 1946 (Date received by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1946, at 11:M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1946, to Oct. 1946, and that I last saw h. M. alive on Oct 23 1946

Immediate cause of death: Coronary Sclerosis — Duration 2 ?
Due to Arteriosclerosis — 4 ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Kohr M. D.
Address 1026 Fort Ave Date signed 10/31/46

G44913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G44913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 DeSoto Rd.
(c) Hospital or institution: 25-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 DESOTA Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA SOMMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife JULIUS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 28 1869

8. AGE: Years 76 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name JOHN KOHAS

13. Birthplace GERMANY

MOTHER 14. Maiden Name MARIE DANULSONT.

15. Birthplace GERMANY

16 (a) Informant MRS GEOLEHR.

(b) Address 1515 DESOTA RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)

(c) Cemetery or crematory WESTERN

Location LOMBARD ST AVE

18 (a) Funeral director GEO LEIMBACH

(b) Address 1215 N LYNDHURST ST

19 (Date received by registrar) NOV 25 1946

Registrar

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/46 19 , at 12 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-1946 to 10-24 1946 and that I last saw h[illegible] alive on 10-23 1946.

Immediate cause of death Myocardial insufficiency Duration 6 Months
chronic hypertension +
Endocardial disease with
Due to hypertrophy + congestive
failure Years
Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W Michel

Address 2901 Edmondson Ave Date signed Nov 25, 1946

X

G44914 BALTIMORE CITY HEALTH DEPARTMENT G44914
CERTIFICATE OF DEATH 170C Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-2
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807- McCollon Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GARFIELD H MATHEWS

3 (b) If veteran, name war Civil
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1909

8. AGE: Years 37 | Months - | Days 5 | If less than one day hr. min.

9. Birthplace Towson Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph C Matthews
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Maggie E. Johnson
15. Birthplace Cockeysville Md.

16. (a) Informant Joseph C. Matthews
(b) Address Emory Av. Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 1946 (Month) (Day) (Year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md.

18 (a) Funeral director Bussard & Mgmt H. Wright
(b) Address 721 Eutaw St

19 (a) OCT 25 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1946, 2.35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Rupture of heart
Fractured ribs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-21-46 at 1.35 A. M.
(b) Where did injury occur? Old Court Rd. 150 ft E of Dulaney Rd
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Driver of truck turned over

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10-21-46

VS 191

G44915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G44915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-1
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Brantly ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Street.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	married

6 (b) Name of husband or wife Mary A. Street
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1890

8. AGE: Years	Months	Days	If less than one day
55 56	11	12	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation
11. Industry or business
12. Name of FATHER Philip Street
13. Birthplace Va.
14. Maiden Name of MOTHER Grace McCulloh
15. Birthplace Va.
16 (a) Informant Mary A. Street
(b) Address 1020 Brantly ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location
18 (a) Funeral director Elroy A. Wilson
(b) Address 7000 Brantly ave
19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

OCT 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1946, at 2:?? P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946, to Oct 22 1946, and that I last saw h.im alive on Oct 22 1946.

Immediate cause of death: Pulmonary Congestion with Failure — Duration 28 hrs.
Due to Congestive Heart Failure
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles T. Woodland M. D.
Address 861 Harlem Ave Date signed 10-31-46

correct age is especially important. Typewriter, pencil or ink may be used.

G44918 3948

MORNING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1147

Registered No. G44916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6-5
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1745 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Morning

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Black

6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-09

8. AGE: Years 37 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Morning

13. Birthplace North Carolina

MOTHER 14. Maiden Name Katie Faulcon

15. Birthplace North Carolina

16 (a) Informant Nearest

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn, Cem

Location Brooklyn, Md

18 (a) Funeral director Clovey O. Wilson

(b) Address 1004 Brantly ave

OCT 25 1946 (c) Huntington Williams, M.D. Registrar

Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1946, at 11 22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1946, to 10-23 1946, and that I last saw h[illegible] alive on 10-23 1946.

Immediate cause of death Metastatic Ca of Lung Duration

Due to Carcinoma of Lung, Lt. & Carcinoma of Lung, Rt.

Due to Carcinoma of Lung

Other Conditions Pneumonia, Lt. Lung, Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation 10-15-46

Major findings of operation Ulcerated cyst Lt. Lung

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Bruce J. Tracy M. D.

Address Johns Hopkins Hosp Date signed 10-25-46

VS 150

X

G44917 Dup. D-6786 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G44917

CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 2
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-46

8. AGE: Years — Months — Days 4 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Karfus Henry

13. Birthplace Alabama

MOTHER 14. Maiden Name Viola W Henry

15. Birthplace North Carolina

16 (a) Informant Karfus Henry

(b) Address 812 Carroll Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 1946 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Location Baltimore City

18 (a) Funeral director Joseph A. Lively

(b) Address 6 W Mt Royal Ave

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 25 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1946, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1946 to 10-24 1946, and that I last saw h[illegible] alive on 10-24 1946

Immediate cause of death: Intracranial Hemorrhage — Duration 7

Due to: Birth injury

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carey M. D.

Address U. Hosp Date signed 10-24-46

correct age is especially important. Physician: please write plainly.

G44918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G44918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira & Lemden
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Ashburton (If outside city or town limits, write RURAL and give town)
(d) Street No. 1257 Linden Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida Brownley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Hiram Wesley Brownley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1853

8. AGE: Years	Months	Days	If less than one day
93	3	3	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business —

FATHER
12. Name Nathaniel Moore
13. Birthplace — Balto., Md.

MOTHER
14. Maiden Name — Martha Brannon
15. Birthplace — " Md.

16 (a) Informant Mr. Edwin Brownley
(b) Address Gun Road, Relay, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 25 1946 (Date received by Registrar) Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1946, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1946 to 10/24 1946, and that I last saw h alive on 10/24 1946.

Immediate cause of death
Respiratory failure
Due to Acidosis-Probably diabetic
Due to Fractured R. femur

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —

of autopsy —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/9/46 at 9:00 P.M.
(c) Where did injury occur? Relay (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall on leg

23. Signature J. H. Mitchell M. D.
Address Madeira & Lemden Date signed 10/24/46

VS 150 C. J. Lubinski per E. L. Merrill MD Maryland General Hosp.

44919 BALTIMORE CITY HEALTH DEPARTMENT G44919

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Poplar Grove St.
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION SHILOH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Goldie M. Shiloh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1878

8. AGE: Years	Months	Days	If less than one day
67	10	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Glass Blower
11. Industry or business Carr Lowry Co.

FATHER
12. Name Eugene Shiloh
13. Birthplace New York

MOTHER
14. Maiden Name -- Rush
15. Birthplace Unknown

16 (a) Informant Mrs. Goldie M. Shiloh
(b) Address 1021 Poplar Grove St.

17 (a) Burial (b) Date thereof 10/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 25 1946 (b) Huntington Williamsburg, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1946 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to Oct 23 1946 and that I last saw h[illegible] alive on Oct 24 1946.

Immediate cause of death: Terminal Bronchopneumonia — Duration: a week

Due to Cardio-Vascular Renal Disease — 10 yrs

Due to

Other Conditions: Terminal Bed Sores — 2 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph N. Zierler M. D.
Address 2348 E. Eager St. Date signed Oct 27 1946

VS 150

G44920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G44920 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walker & Cator Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 S. Brunswick (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry William Graham

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1891

8. AGE: Years 55 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Princeton, Ind. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Union Stockyards

FATHER 12. Name —
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Hospital Record
(b) Address St. Agnes' Hospital

17 (a) Disposal (Burial, cremation, or removal) (b) Date thereof Oct. 25/46 (month) (day) (year)
(c) Cemetery or crematory Princeton, Ind.
Location

Name of funeral director Wm. J. Kirk
18 (a) Funeral director
(b) Address Baltimore Pulaski Dist.

19 OCT 25 1946 Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1946 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1946 to 10/22 1946 and that I last saw h[illegible] alive on 10/22 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifton Smith Jenkins M.D. M. D.
Address St. Agnes Hosp. Date signed 10/23/46

G44921

CWK-108156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G44921 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 2-
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 McCullough Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Thelma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6-1906

8. AGE: Years	Months	Days	If less than one day hr.	min.
40	5	19		

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter
13. Birthplace Maryland

MOTHER
14. Maiden Name Sadie Bond
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Oct 28.1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bush Park
Location Near Cooksville Howard

18 (a) Funeral director H. M. Snyder
(b) Address Mt. Airy

19 (a) (b)
(Date rec'd by Registrar) Registrar

OCT 25 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1946, at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1946 to Oct. 25 1946, and that I last saw h 1malive on Oct. 25 1946.

	Duration
Immediate cause of death Surgical shock	7 days
Due to Pulmonary tuberculosis	2 yrs
Due to	
Other Conditions Bronchial asthma (Include pregnancy within 3 months of death)	

Date of operation 10-18-46
Major findings of operation: Pulmonary tuberculosis
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas O'Neill M. D.
Address Balto. City Hosp's Date signed 10-25-46

X

14922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131a

Registered No. G41922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd
(c) Hospital or institution:
Skinner Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d
(e) Length of stay in Baltimore (yrs., mos., or days) 19d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne's
(c) City or town Sudlersville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie E. Massey

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife: Massey
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Oct 27 1864

8. AGE: Years	Months	Days	If less than one day
82	11	29	hr. min.

9. Birthplace Queens Anne Co Md
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Comegys
13. Birthplace Md

MOTHER
14. Maiden Name Laura Emory
15. Birthplace Md

16. (a) Informant Mrs John Coppage
(b) Address Church Hill Md

17 (a) Burial (b) Date thereof Oct 28 1946
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sudlersville
Location Sudlersville Md

18 (a) Funeral director Clay L Lane
(b) Address Church Hill Md

19 (a) OCT 26 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946, at 12.45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1946 to Oct 26 1946, and that I last saw her alive on Oct 25 1946.

Immediate cause of death	Duration
Bronchopneumonia	2d.
Cerebral Hemorrhage	14d.
Due to Arterio Sclerosis	30 y
Hypertension	30 y
Due to Old Infarctions Kidneys	30 y
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. S. A. Stevens M. D.
Address 7818 Harford Rd Date signed Oct 26 46

VS 150

44923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G44923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Melville Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Melville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Priscilla Scaramucci

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Marion Scaramucci

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7th 1875

8. AGE: Years: 71 | Months: 6 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Sicily Italy (town, county, and state)

10. Usual Occupation: At Home

11. Industry or business: Self

FATHER
12. Name: Joseph Siciata
13. Birthplace: Italy

MOTHER
14. Maiden Name: Philomenia (Unknown)
15. Birthplace: Italy

16 (a) Informant: Dominick Scaramucci
(b) Address: 600 Melville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/28/46 (mo.) (day) (year)
(c) Cemetery or crematory: St. Vincents Cem
Location: Balto Md

18 (a) Funeral director: William Cook Inc.
(b) Address: 6217 St. Paul St.

19 (a) OCT 26 1946 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 24th 1946, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1946 to Oct 24 1946 and that I last saw h alive on Oct 23 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Coronary Occlusion	
Due to Arteriosclerotic cardio vascular renal disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Slonofsky M.D.
Address: 601 N. Howard St Date signed: 10/27/46

VS 150

44921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G44921
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 431 E. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Rosenberger

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-01-8050

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21st 1877

8. AGE: Years	Months	Days	If less than one day
69	1	4	hr. min.

9. Birthplace (Town, county, and state) Balto. Md.
10. Usual Occupation Retired Postal Mail Clerk
11. Industry or business Dunn & Bradstreet

FATHER 12. Name	Henry Rosenberger
13. Birthplace	Germany
MOTHER 14. Maiden Name	Elizabeth (Unknown)
15. Birthplace	Germany

16 (a) Informant Lyman R. Rosenberger
(b) Address 614 Melville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location Balto, Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 26 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1946, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 19 46, to 10-25 19 46, and that I last saw him alive on 10-24 19 46

Immediate cause of death: Carcinoma of Bladder — Duration 3 mos.

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. D. Thyson M. D.

Address 11 E. Chase St. Date signed 10-25-46

correct age is especially important. Physicians: please write plainly.

VS 150

G44925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G44925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 Warrenton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 39 Warrenton Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schroder Taylor White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Violett Poe

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 31 1879

8. AGE: Years 67 | Months 2 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, state or state)

10. Usual Occupation Architect

11. Industry or business Architecture

FATHER — 12. Name Charles Ridgely White
13. Birthplace Howard Co Md

MOTHER — 14. Maiden Name Eliza Wyncheste Taylor
15. Birthplace Balto Md

16 (a) Informant William Poe White
(b) Address 39 Warrenton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28 1946 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Balto Md

18 (a) Funeral director Henry W. Armstrong & Son
(b) Address Orchard & McCulloh Sts

19. OCT 26 1946 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1946, at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/44 19 to 10/25/46 19, and that I last saw him alive on 10/22/46 19

Immediate cause of death: Coronary artery Sclerosis
Due to: Myocardial disease

Duration
1 yr 10 mo

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances W. Gluck M. D.
Address 715 Park Ave Date signed 10/25/46

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits write RURAL and give town)
(d) Street No. 1317 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Kolb
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Lotta Mary

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 20 1867

8. AGE: Years 79 | Months 7 | Days 5 | If less than one day — hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Retired

FATHER 12. Name John Kolb

13. Birthplace Germany

MOTHER 14. Maiden Name Bertha Mattes

15. Birthplace Germany

16 (a) Informant Mr Geo Kolb

(b) Address 1312 W Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 28 46 (month) (day) (year)

(c) Cemetery or crematory Loudenschlager

Location 4300 Edmondson Ave

18 (a) Funeral director John J Gorman Sons

(b) Address 2403 Eutaw Place

(c) Address Huntington Williams, M.D.

OCT 26 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1946, at 1205 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 20 1946 to 10 25 1946.
and that I last saw h[illegible] alive on 10 25 1946

Immediate cause of death Cerebral Hemorrhage — Duration 4 days

Due to —

Due to —

Other Condition Arteriosclerosis — ?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature H. P. Abaye M. D.

Address 33 [illegible] Date signed 10 28 46

X Embalmed Md 10/28/46

correct age is especially important. Physicians please write plainly.

~~41927~~ BCH G54104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓64

Registered No. G41927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2700 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas T. Dare

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-14-1946

8. AGE: Years | Months 3 2 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas J. Dare Sr
13. Birthplace Baltimore - Md.

MOTHER 14. Maiden Name Theresa Marsiglia
15. Birthplace Balto. Md.

16 (a) Informant Thomas J. Dare Sr
(b) Address 2700 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director John E. Miller Jr.
(b) Address 2736 E. Oliver St.

19 OCT 26 1946 (Date received by registrar) (c) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1946, at 11.10 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Status thymicolymphaticus
Cerebral edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 10/25/46

G44928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G44928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph G Flint

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~:
M	W	Married

6 (b) Name of ~~husband or~~ wife Martha Flint

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7th 1877

8. AGE: Years	Months	Days	If less than one day
69	5	17	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation City Employee

11. Industry or business City of Balto.

FATHER
12. Name James A. Flint Sr.
13. Birthplace Eastern Shore of Md.

MOTHER
14. Maiden Name Mary M. Popkp
15. Birthplace Unknown

16 (a) Informant Martha Flint (Wife)
(b) Address 612 Poplar Grove St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 26 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1946 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained *Autopsy, Inspection or Inquiry*
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lorraine M.D. Medical Examiner.
Date signed 10/28/46

41923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓92D

Registered No. 41929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DA
(e) Length of stay in Baltimore (yrs., mos., or days) 30A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 South Central
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses ADKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-1886

8. AGE: Years 60 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation Odd Jobs

11. Industry or business

FATHER
12. Name JOSEPH ADKINS
13. Birthplace MD

MOTHER
14. Maiden Name REBECCA
15. Birthplace MD.

16 (a) Informant MARY C. GODDARD
(b) Address 829 N. CAROLINE ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/46 (month) (day) (year)
(c) Cemetery or crematory MT. Calvery
Location Baltimore, md.

18 (a) Funeral director Charles A. Rice
(b) Address 405 N. Calhoun St.

19 (a) OCT 26 1946 Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/46 19 , at 1:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John G. Ward, M.D.
Medical Examiner
Date signed 10/24/46

VS 181

C41930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C41930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME E. Harry Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Anna Schmuck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10th 1869

8. AGE: Years 76 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Machinist (Retired)

11. Industry or business Continental Can Co.

FATHER 12. Name Edmund L. Robinson

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Emma L.

MOTHER 15. Birthplace Md.

16 (a) Informant Mrs. Vitek

(b) Address 327 E. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto.

18 (a) Funeral director E. J. Flannery & Son

(b) Address 1938 E. Lafayette Ave.

19 Date OCT 26 1946 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28th 1946, at 1:40 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1946, to 10/25 1946 and that I last saw him alive on 10/21 1946

	Duration
Immediate cause of death: Bronchopneumonia	5 days
Due to: Hypertension C.V. Disease	10 yrs
Due to: Hypertrophy Prostate Gland	1 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Karl Hammann

Address 2123 N. Patterson Park Ave Date signed 10/26/46 M. D.

VS 150

correct age is especially important. Physicians please write the cause of death clearly and legibly.

G44931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered G44931

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Sylvan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET M. PRITCHARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Ernest F. Pritchard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1859

8. AGE: Years	Months	Days	If less than one day
87	1	11	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Horton Miskell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace --

16 (a) Informant Mr. Ernest Pritchard
(b) Address 3108 Ferndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b) Huntington Williams, M.D.
OCT 26 1946
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1946, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1946 to Oct 24 1946 and that I last saw her alive on Oct 23 1946

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	2 years
Due to Generalized arteriosclerosis	10 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Sawyer M. D.
Address 4808 Harford Rd. Date signed 10/25/46

X

G44932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G44932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Asquith Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 June 1946

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County Vance
(c) City or town Henderson (If outside city or town limits, write RURAL and give town)
(d) Street No. Route # 5 Box 204 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Richardson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: Walter Richardson
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 Months Days If less than one day hr. min.

9. Birthplace: Vance Co. N. C. (Town, county, and state)
10. Usual Occupation: farm Helper
11. Industry or business: Farm -

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: Ann Morrow
15. Birthplace: Vance Co. N. C.

16 (a) Informant: Bertha Alston
(b) Address: 813 Asquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 27 46 (month) (day) (year)
(c) Cemetery or crematory: Mt Zion
Location: Vance Co. N. C.

18 (a) Funeral director: Bryant Francis Mc Knight
(b) Address: 731 Asquith St Baltimore Md

19 (a) Oct 26 1946 (b) Huntington Maryland
Filed (c) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 October 1946, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 June 1946, to 24 Oct 1946, and that I last saw h e alive on Oct 24 1946.

	Duration
Immediate cause of death: Hemiplegia	4 days
Due to: Hypertensive cardio vascular disease	? yrs
Due to:	
Other Conditions: Arteriosclerosis	? yrs

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: Non

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury
23. Signature: T. A. Thorpe
Address: 1422 E. Chase St Date signed: 10/24/46 M. D.

VS 150

G24933 SITTKA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. G24933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 William St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Sittka

3 (b) If veteran, name war: —

3 (c) Social Security Account No. None.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alois

6 (c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Jan 10 1873

8. AGE: Years: 73 | Months: 9 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation:

11. Industry or business: At Home

FATHER — 12. Name: Sylvester Wahgartner
13. Birthplace: Germany

MOTHER — 14. Maiden Name: Maria Sonnentaiter
15. Birthplace: Germany

16 (a) Informant: Alois Sittka
(b) Address: 1121 William St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10 29 46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4300 Belair Rd

18 (a) Funeral director: Martin W. Biggelin
(b) Address: 37 S. Amity St.

19. OCT 26 1946 (Date rec'd by Local Reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1946 at 9:15 A M

21. I certify that death occurred on the date above stated that I attended deceased from Oct 15 1946 to Oct 25 1946.
and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr

Due to: Hypertension Arterial — 6 mos.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: O B Wheeler M. D.
Address: 1279 Fillmore St Date signed: 10/29/46

VS 150

G44934 BCH 659360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √157a

G44934 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3439 Dudley Road
(c) Hospital or institution: * * 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) *
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3439 Dudley Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country * * *

3 (a) **FULL NAME** Nancy May Dankard

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife * *
6 (c) If alive, give age * years
7. Birth date of deceased (mo., day, yr.) Oct 14 - 46
8. AGE: Years | Months | Days: 11 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation * *
11. Industry or business * *

FATHER
12. Name James Dankard
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ethel Chester
15. Birthplace Baltimore

16 (a) Informant James Dankard
(b) Address 3439 Dudley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 112 W. Mt Royal Ave

OCT 26 1946 Huntington Williams, M.D.
(Date filed by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct. 1946, at 7:NP M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Oct 1946 to 25 Oct 1946 and that I last saw him alive on 24 Oct 1946

Immediate cause of death: Congenital Disease of Heart — Duration: 1 hr.
Due to
Due to
Other Conditions: Hydrocephalus — Duration: 1 wk.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Hammond
Address 501 Sheridan Ave Date signed 25 Oct 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

614935 BALTIMORE CITY HEALTH DEPARTMENT 614935
CERTIFICATE OF DEATH 93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 942 S. Sharp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 942 S. Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth V. Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 29 1880

8. AGE: Years	Months	Days	If less than one day
66	8	24	hr. min.

9. Birthplace Elkcott City Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Burba Nelson
13. Birthplace Md.

MOTHER
14. Maiden Name Alvesta Thornton
15. Birthplace Md.

16 (a) Informant Alice Moulton
(b) Address 942 S. Sharp St
17 (a) Burial (b) Date thereof 10-27-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Lyty
18 (a) Funeral director Samuel McChesney & Son
(b) Address 601 N. Gilmor St
19 (a) [illegible] (b) Huntington Williams, M.D.
Address 701 N. Carey St Date signed 10/27/46

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct. 23 1946, at 4:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1946, to Oct. 23 1946 and that I last saw her alive on Oct. 21 1946.

Immediate cause of death	Duration
Hypertensive Cardiovascular disease	7
Due to Hypertension	
Due to	
Other Conditions Arteriosclerosis Chronic Bronchitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. Walter Stevenson M. D.
Address 701 N. Carey St Date signed 10/27/46

VS 2

G44936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

G44936 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 N. Gay
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. Gay (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Thomas Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Langston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 1912

8. AGE: Years	Months	Days	If less than one day
34	3	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Bowman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Butler
15. Birthplace Md.

16 (a) Informant Myrtle Saunders
(b) Address 1617 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 (a) OCT 26 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1946 to Oct 23 1946
and that I last saw her alive on Oct 23 1946

Immediate cause of death Cerebral Hemorrhage — Duration 3 hrs
Due to Hypertension — Duration Don't Know
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. D. Walters M.D.
Address 1443 Fraser Date signed 10/26

VS 8

G44937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G44937

Please write the cause of death clearly and legibly. Report age in years if known, or approximate if not known. Physicians: please write plainly and fill in all items.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 W. Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. JOHN L. GOODE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
NO	None	Male	C	Widowed

6 (b) Name of husband or wife Maggie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/7/1873

8. AGE: Years	Months	Days	If less than one day
72	11	17	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Louis Goode
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Elizabeth Young(Daug).
(b) Address 1406 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/46 (month) (day) (year)
(c) Cemetery or crematory Farmers
Location Clover, Va.

18 (a) Funeral director Charles G.Cooper
(b) Address 510-12 N.Carrollton Ave

19 1946 Recorded by registrar Huntington Williams M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24th 1946 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1946 to Oct 24 1946, and that I last saw h/m alive on Oct 24 1946.

Immediate cause of death	Duration
Nephritis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Douglas Sheppard
Address 1931 W Franklin Date signed 10/27/46

X

G44938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G44938 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hillen & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Wellesley St. #29 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Toth

3 (b) If veteran, name war No
3 (c) Social Security Account No. 216-03-2434

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marie A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1887

8. AGE: Years 59 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER 12. Name deceased Fred Toth
13. Birthplace Md.

MOTHER 14. Maiden Name deceased (Clara ?)
15. Birthplace Md.

16 (a) Informant Marie A. Toth
(b) Address 601 Wellesley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Williams Cook Dunn
(b) Address 1217 St. Paul St

27 1946 (Date received by registrar) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1946, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1946 to Oct. 25 1946, and that I last saw him alive on Oct. 25 1946.

Immediate cause of death Cardiac failure — Duration
Cerebral vascular accident Left
Hypertension C.V.D.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address St Agnes Date signed 10-25-46

Subject age is especially important. Physicians: please write the causes of death clearly and legibly.

G44939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G44939 Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lay over + Dukeland
(c) Hospital or institution: West Balt. inf. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Mc Mechen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Liebegott

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NAB

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband Ralph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 29 1866

8. AGE: Years	Months	Days	If less than one day
80	6	27	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name (Unknown) Wehrecht
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Saunders
15. Birthplace "

16 (a) Informant Mrs. Frida Wilcke
(b) Address 3640 Coolidge Ave

17 (a) Burial (b) Date thereof 10/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Cedar Hill
Location Brooklyn A.A.Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) [illegible] 1946 (b) [illegible]
Date received by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 October 1946 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1946, to Oct 26 1946, and that I last saw h[illegible] alive on 26 Oct 1946

Immediate cause of death	Duration
Cardio Resp. Failure	
Due to Arteriosclerotic Hrt. C.V. Renal Dis.	
Due to Nephritis Chronic	
Other Conditions Prostatomegaly Hypertension Rod. Cystic Pyelonephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

A VITAM 1&2 5%

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter A. Speck M. D.
Address West Balto Gen Hosp Date signed 26 Oct 46

VS 150

G44910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G44910 Registered No.

Please write the cause of death clearly and legibly. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2219 GALLOW AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 GALLOW AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS MAZER

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife [redacted] Julia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation MERCHANT
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address 2219 GALLOW AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-27-46 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Pikesville Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St.

OCT 27 1946 (Date rec'd by Registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1946, at 1:18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/46 19__, to 10/25 1946, and that I last saw him alive on 10/25 19 46.

Immediate cause of death: acute dilatation of heart — Duration

Due to

Due to

Other Conditions Coronary thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Schudeveld M.D.
Address 2225 Linden Ave Date signed 10/26/46

VS 150

G44911 — BALTIMORE CITY HEALTH DEPARTMENT — G44911 Registered No.

CERTIFICATE OF DEATH 1946

Please write the cause of death clearly and legibly. Physicians: please write exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 N. Woodington Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N. Woodington Road (If institutional location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN CAREY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	M	W	Married

6 (b) Name of husband or wife Anna Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1946 ??

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	9	4		

9. Birthplace Berlin, Maryland (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Police Department

FATHER — 12. Name Joshua Carey
13. Birthplace Berlin, Md.

MOTHER — 14. Maiden Name Julia Fossitt
15. Birthplace Berlin, Md.

16 (a) Informant Anna Marie Carey (Wife)
(b) Address 718 N. Woodington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 46 (month) (day) (year)
(c) Cemetery or crematory St. Pauls P.E.
Location Berlin, Maryland

18 (a) Funeral director Walter Bradley
(b) Address 1922 W. North Avenue

19 (a) Date received by registrar OCT 27 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1946, at 5 15/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1946, to 10/25 1946 and that I last saw h[illegible] alive on 10/25 1946

Immediate cause of death: Myocardial insufficiency — Duration 2 mo.
Due to Hypertension — ?
Due to Arteriosclerosis — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter
Address 3408 W[illegible] Ave Date signed 10/25/46

X

G44912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G44912 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write in ink. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Roland Ave, (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edwin Tracy Cole

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Mar

6 (b) Name of husband or wife Nellie Tallmans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1869

8. AGE: Years	Months	Days	If less than one day
77	4	18	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business None

FATHER
12. Name Elijah Cole
13. Birthplace Md

MOTHER
14. Maiden Name Arabella —— Tracy
15. Birthplace Md

16 (a) Informant Mr — Cole (Son)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) (b) (City or county) (State) (Registrar)

OCT 24 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1946, at 5m a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946 to 10-25 1946, and that I last saw him alive on 10-24 1946

Immediate cause of death: Pneumothorax — Duration 6-7 days
Due to: Senile emphysema
Due to:
Other Conditions: Arterio-sclerotic Heart Disease.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford N. Fahlen Jr. M.D.
Address Union Memorial Hosp Date signed 10-25-46

X

G41943 — BALTIMORE CITY HEALTH DEPARTMENT — G41943 (Registered No.)

CERTIFICATE OF DEATH 122B

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert - Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5-9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August H. Bergenkamp

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — — (1867)

8. AGE: Years	Months	Days	If less than one day
5-9			hr. min.

9. Birthplace Balto, Md (town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business

FATHER
12. Name Fred T. Bergenkamp
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wertlein
15. Birthplace Germany

16 (a) Informant Mrs. Anna M. Bergenkamp
(b) Address 61 South St. New Jersey

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer, Baltimore, Md
Location

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St., Huntingdon Williams, Md.

19 (a) OCT 27 1946 (b) — Registrar
(date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1946 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1946 to 10/25 1946, and that I last saw h~~e~~ alive on 10/24/1946

Immediate cause of death	Duration
Cardiac failure	
Due to Cardiac decompensation	
Due to Intestinal obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/25/46
Major findings of operation: Intest. obstruct. perforation
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Sigler Jr. M.D.
Address Mercy Hospital Date signed 10/25/46

VS 150

G44911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

G44911 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write exact age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Gorsuch Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 79 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Gorsuch Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L. Donovan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret Carr
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1867

8. AGE: Years	Months	Days	If less than one day
79	8	11	--hr. --min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name Michael Donovan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Johnstone
15. Birthplace England

16 (a) Informant Robert M. Donovan
(b) Address 725 E. 37th Street

17 (a) Burial (b) Date thereof 10/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) 1946 (b) Huntington Willard, Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1946, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Oct. 23 1946, and that I last saw him alive on Oct. 23 1946.

Immediate cause of death
Coronary Embolism
Due to arteriosclerosis,
Due to epilepsi
Other Conditions metal upset
(Include pregnancy within 3 months of death)

Duration: Months / Years

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Strickler M. D.
Address 612 Gorsuch Date signed Oct. 25 1946

G44915 BALTIMORE CITY HEALTH DEPARTMENT G44915

CERTIFICATE OF DEATH 1310

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write this information carefully; it is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 N. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 N. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie B. Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1885

8. AGE: Years 61 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Brunswick Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Thomas
13. Birthplace Brunswick Co. Va

MOTHER
14. Maiden Name Phyllis Taylor
15. Birthplace Brunswick Co. Va

16 (a) Informant Mrs Hattie Rice
(b) Address 1429 N. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Thos. Chas. A. Hulbert
(b) Address 1631 Druid Hill Ave

19 (a) OCT 29 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1946, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4, 1946 to Oct 24, 1946, and that I last saw h[illegible] alive on Oct 24th 19

Immediate cause of death	Duration
Hypertension Cardio Renal Disease	2 yrs
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 312 E 23rd St Date signed 10-26-46

VS 150

G44916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 C

G44916 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 60 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3120 Barclay St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Robert C. Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, (1895) 1896

8. AGE: Years 84 (61) Months 11 3 Days 8 16 If less than one day hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Robert L. Marshall

(b) Address 3120 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1946 (month) (day) (year)

(c) Cemetery or crematory Balto. Nat'l. Cem.

Location Baltimore Md.

18 (a) Funeral director Mrs. Lee A. Mullen

(b) Address 1691 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1946, 6:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1946, to 10-22 1946, and that I last saw him alive on 10-22 1946.

Immediate cause of death: Acute nephritis — Duration

Due to Carcinoma of urinary bladder

Due to

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. R. Jackson M. D. Date signed 10-23-46

Address 1514 Division St

VS 160

G41917 BALTIMORE CITY HEALTH DEPARTMENT G41917
CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~925 E. Biddle St~~ 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Maria Carpenter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Edward Carpenter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ? 1860
8. AGE: Years 86 Months Days If less than one day hr. min.
9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Sandy Dawes
13. Birthplace ?

MOTHER
14. Maiden Name Cecelia Benson
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street Balto.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28, 1946 (month) (day) (year)
(c) Cemetery or crematory St Louis Location Howard Co. Md
18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E Biddle St Huntington Williams, M.D.
19 (a) 1946 (Filled in by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-25 1946, at 6:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1- 1946, to Oct 25 1946, and that I last saw her alive on Oct 24- 1946.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. Gill Hall M. D.
Address 1631 E. North av Date signed 10/26-46

VS 8

G44918 — BALTIMORE CITY HEALTH DEPARTMENT — G44918 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 E. Biddle St
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Gunther

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 174-07-7025

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Josephine Gunther
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1891

8. AGE: Years	Months	Days	If less than one day
55	1	2	hr. min.

9. Birthplace Utica, Md. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Wm. Gunther
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Townsley
15. Birthplace Md

16 (a) Informant Mrs. Wm. Gunther
(b) Address 928 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Forest Hill, Methodist
Location Harford Co. Md

18 (a) Funeral director Paul Windefeld
(b) Address 900 E. Biddle St.

19 (a) Date filed by registrar 1946 (b) Burlington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 October 1946, at 1:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer Jr. M.D. Medical Examiner.
Date signed 26 Oct. 1946

G44919 BALTIMORE CITY HEALTH DEPARTMENT G44919
CERTIFICATE OF DEATH 1170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town ~~Baltimore~~ Hebbville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Pine Ave #7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Dettmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie Dettmer
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 17-1887

8. AGE: Years 59 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Md. Hebbville
(Town, county and state)

10. Usual Occupation Carpenter

11. Industry or business

BORN | FATHER
12. Name Henry Dettmer
13. Birthplace Baltimore County, Md.

BORN | MOTHER
14. Maiden Name Elizabeth McCannon
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Annie Dettmer
(b) Address 2112 Pine Ave., Hebbville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director
(b) Address 4510 Liberty Heights Ave.

29 1946 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1946, at 5 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 25 1946 and that I last saw him alive on Oct 25 1946

Immediate cause of death Cardiac failure — Duration
Terminal bronchio Pneumonia
Due to Hypertensive Cardio-Vascular Disease - Bleeding
Due to Peptic ulcer.
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Manuel Cezula
Address Md. General Hosp. Date signed 10/25/46

If death occurred in a hospital or institution, write the causes of death clearly and legibly. Physicians: please write correct age in space provided. Information as to age is especially important.

VS 150

G44950 BALTIMORE CITY HEALTH DEPARTMENT G44950
CERTIFICATE OF DEATH 1946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 No. Ellamont St
(c) Hospital or institution Jewish Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town insert word RURAL and name town)
(d) Street No. 120 N Wolf St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes name country

3 (a) FULL NAME Anna Hoffman
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Louis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 71 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name unknown
13. Birthplace Russia
MOTHER 14. Maiden Name unknown
15. Birthplace Russia
16 (a) Informant Harry Hoffman
(b) Address 2003 Keyser ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-46 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location North Point-Edgemere Rd
18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St
19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md

MEDICAL CERTIFICATION
20. DATE OF DEATH 10-27-1946 at 7:17 M
21. I certify that death occurred on the date above stated; that I attended deceased from October 3, 1946 to Oct. 27 1946, and that I last saw her alive on Oct. 26, 1946

Immediate cause of death	Duration
Acute edema of the lungs	2 days
Due to Chronic mitral insufficiency	24 days
Due to Arteriosclerosis	24 days
Other Conditions Cancer of the sigmoid and peritoneum	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Gilbert E. Rudman
Address 2517 W. Balto St. Date signed 10/27/46 M. D.

Please write the causes of death clearly and legibly. Physicians: please see that age is especially important.

OCT 28 1946

X

G44951 DC-G-60478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G44951 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution:
FRANKLIN SQUARE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pleasant Hills Park
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Gayo

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 26 Oct 46

8. AGE: Years	Months	Days	If less than one day
—	—	—	— hr. 41 min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Nicholas J. Gayo
13. Birthplace Locust Point, Md

MOTHER
14. Maiden Name Rosalind I. Jones
15. Birthplace Balto, Md.

16 (a) Informant Rosalind I. Jones
(b) Address Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28, '46 (month) (day), (year)
(c) Cemetery or crematory Pleasant Hill
Location Owings Mills.

18 (a) Funeral director Wm. Berryman + Sons
(b) Address Reisterstown, Md.

19 (a) Filed OCT 28 1946 (b) Registrar Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Oct 1946, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Oct 1946, to 26 Oct 1946, and that I last saw her alive on 26 Oct 1946

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature and title Franklin Square Hospital M. D.
Address Franklin Square Hospital Date signed

G44952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G44952 Registered No.

Type or write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Mary Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Mainster

3 (b) If veteran, name war	3 (c) Social Security Account No.
W/	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carrie B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Raymond F. Mainster
(b) Address 3716 Croydon Rd
17 (a) Burial (b) Date thereof 10/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Tillman & Son
(b) Address 1214 E Pont St
OCT 28 1946 (Date filed by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 28 1946, to Oct 26 1946; and that I last saw him alive on Oct 25 1946.

Immediate cause of death	Duration
MYOCARDIAL INSUFFICIENCY	- 2 yrs.
Due to ARTERIOSCLEROSIS	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Kleiman M. D.
Address 3803 Edmondson Date signed 10/27/46

VS 150

641953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 641953

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4429 Bruna Vista
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or incorporated town RURAL and give town)
(d) Street No. 4429 Bruna Vista
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Danker

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband Marion Danker

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) Oct 25th 1865

8. AGE: Years 81 | Months 0 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name John M. Boring
13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden Name Matilda Fleagle
15. Birthplace Carroll Co. Md.

16 (a) Informant Margaret D. Rodgers
(b) Address 4429 Bruna Vista Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery Green Mount
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

OCT 28 1946 (Date received by registrar) (Signature) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/46 19 , at 10½ M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ___ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ___ at ___ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Evans, M.D.
Medical Examiner.
Date signed 10/27/46

G44954 G44954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 8 3a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Bank St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Anna Marie Woods

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles Chris. Woods

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1884

8. AGE: Years 62 | Months 1 | Days 3 | If less than one day hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

FATHER
12. Name Michael Shelby
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Gettman
15. Birthplace Baltimore, Md.

16 (a) Informant Charles C. Woods
(b) Address 3503 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28/46 (month) (day) (year)

(c) Cemetery or crematory Schwartz's
Location Gay & Pennsylvania Ave.

18 (a) Funeral director John F. Miller
(b) Address 2334 Jefferson St.

OCT 28 1946 (Date received by registrar) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1946 at 5.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1926 to Oct 24 1946 and that I last saw her alive on Oct. 23 1946.

	Duration
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions Pulmonary Edema	1 day

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo Schlenger MD
Address 3034 E Balto. St. Date signed 10-24-46

VS 2

X

14955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G44955 Registered No. 9441

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 John St
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 John St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME James B. Leonard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/11/46

8. AGE: Years 0 | Months 8 | Days 16+? | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name James W. Leonard
13. Birthplace Arkansas

MOTHER
14. Maiden Name Selma Auskins
15. Birthplace North Carolina

16 (a) Informant James W. Leonard
(b) Address 1516 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 46 (month) (day) (year)
(c) Cemetery or crematory Custis Co.
Location Hatteras N. Carolina

18 (a) Funeral director John A. Mullen
(b) Address 2304 Jefferson St

DCT 28 1946 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Oct 1946, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Oct 1946 to 16 Oct 1946 and that I last saw h. 1m alive on 16 Oct 1946

Immediate cause of death: Circulatory Collapse — Duration

Due to TBC meningitis

Due to TBC, pulmonary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy TBC Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Hatcher M. D.
Address University Hosp. Date signed 27 Oct 46

1956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C41956

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD PITTS NEWTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Anson Texas
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Mate

FATHER
12. Name Edward P. Newton
13. Birthplace Anson Texas

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Oscar Berggen
(b) Address 1702 Thames St

17 (a) Burial (b) Date thereof Oct 27 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Anson Texas

18 (a) Funeral director Leo F. Grook
(b) Address 1701-03 N Patterson Park ave

OCT 28 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1946, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 10/25/46

G11957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G11957
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raffel Bernstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Yuda
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Fannie Bernstein
(b) Address 2008 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave

18 (a) Funeral director Jos. Lewis Inc
(b) Address 1429 E Balto St. Huntington Williams, M.D.

19 (a) 10-28-1946 (Date received by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1946, at 12 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 19 46 to Oct 27 19 46 and that I last saw h alive on Oct 27 19 46

Immediate cause of death: Cerebro vascular accident — Duration

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Samuel D. Gabry M. D.
Address Sinai Hospital Date signed 10/27/46

VS 150

X

G44958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G44958 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline
(c) Hospital or institution: St. Joseph's Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2136 Smallwood St-16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Chester

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Late George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/16/80

8. AGE: Years	Months	Days	If less than one day
66	4	8	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER	12. Name Unknown
	13. Birthplace Unknown
MOTHER	14. Maiden Name Unknown
	15. Birthplace Unknown

16 (a) Informant Mrs. Ernest Warner
(b) Address 2136 Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28 1946 (month) (day) (year)
(c) Cemetery or crematory Loyola Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A Wiltse
(b) Address 4101 Edmondson Ave

19 (a) [illegible] (b) Huntington Williamsport, Md.
OCT 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946 to Oct 24 1946 and that I last saw h[illegible] alive on Oct. 24 1946

Immediate cause of death
Cardio-Respiratory failure — Duration
Due to Bronchio-Pneumonia
Due to Ruptured Diverticulitis Peritonitis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10/19/46
Major findings of operation Peritonitis + Ruptured diverticulitis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Wells M. D.
Address St Joseph's Hosp Date signed 10-24-46

G44959 — BALTIMORE CITY HEALTH DEPARTMENT — G44959

CERTIFICATE OF DEATH ✓ 46F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 Gilson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Hammonds Ferry Rd (If rural) give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Albert Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1878

8. AGE: Years	Months	Days	If less than one day
67	10	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER: 12. Name — Merson
13. Birthplace

MOTHER: 14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Albert Jenkins
(b) Address 2911 Hammonds Ferry Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28/46 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Odenton Md.

18 (a) Funeral director Harry A. Wiltze
(b) Address 4101 Edmondson Ave

19 (a) (b)

OCT 28 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1946 to Oct 25 1946 and that I last saw h[illegible] alive on Oct 25 1946

Immediate cause of death
Carcinoma — Gall-bladder & Liver — Duration about 15 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation about Apr 15 46
Major findings of operation: at St. Agnes hospital —
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Dr. Herman Seidel
Address 2404 Eutaw Pl Date signed 10/24/46

X

G44960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G44960 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. Crockett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Sadie (Ward)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1864

8. AGE: Years 81 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Julius Crockett
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Worthington
15. Birthplace Md

16 (a) Informant Mrs George Hahn
(b) Address 1936 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28 1946 (month) (day) (year)
(c) Cemetery or crematory Dansgreen
Location Dansgreen Maryland

18 (a) Funeral director Henry H. Wittle
(b) Address 4101 Edmondson Ave

19 (a) (Date received by Local Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 26 1946 and that I last saw him alive on Oct 20 1946.

	Duration
Acute Myocarditis	2 days
Due to (c) Senile Substitution	unknown
Due to (b) Hypostasis	
Due to (a)	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Walter F. Donner M. D.
Address 401 Edmondson Ave Date signed Oct 28 1946

VS 150

PRINT NAME, WRITE ONE LETTER OR FIGURE IN EACH SQUARE, AND CHECK ALL ENTRIES FOR correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44961

HEALTH DEPARTMENT—CITY OF BALTIMORE

G44961

CERTIFICATE OF DEATH

1. PLACE OF DEATH Edgewood Nursing Home ✓ Belloma 95c Registered No.

CITY OF BALTIMORE: (No. 6000 Balonia Ave. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 72 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Mrs. Jeanetta C. Hart. If U. S. Veteran specify WAR No.

(a) Residence: No. 6000 Balonia Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
FM	White	Widowed

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of William G. Hart

6. DATE OF BIRTH (month, day, year) Jan. 24, 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	9	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) 7 years Mo. 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Alabama

FATHER

13. NAME Jacob F. Scott

14. BIRTHPLACE (city or town) (State or country) Baltimore

MOTHER

15. MAIDEN NAME Helen T. Ihmen

16. BIRTHPLACE (city or town) (State or country) Georgia

17. INFORMANT Mrs. Irma Scott Clark

(Address) 2723 W. Lanvale St.

18. BURIAL, [redacted]

Place Loudon Park Date 10/30/48

19. UNDERTAKER Geo. W. Little

(Address) 2700 Edmondson Ave.

20. FILED Huntington Williams M.D.
Registrar

OCT 28 1948

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct. 27, 1948

22. I HEREBY CERTIFY, That I attended deceased from Oct. 27 19 34 to Oct 27 19 48

I last saw her alive on Oct 26 19 48 Death is said to have occurred on the date stated above, at 8a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
I. Pancytopenia	early 1948
Other contributory causes of importance: Cardiac Asthma	early 1948

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury — 19—

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) L. A. Richardson M. D.

(Address) 112 W. 20th St.

X

OCCUPATION is very important. See instructions on back of certificate.

G44962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G44962 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Siani
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Erna B. Winterling

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Rudolph M. Winterling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1894

8. AGE: Years	Months	Days	If less than one day
52	8	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Receptionist
11. Industry or business Balto. ear Eye Nose & Throat Hosp.

FATHER
12. Name Max Ball
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Laupheimer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Julian B. Littauer
(b) Address 4006 Dorchester Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date received) (b) Huntington Williams, M.D.

OCT 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1946 at 6.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 15 1946, to October 25 1946, and that I last saw h[er] alive on October 25 1946.

Immediate cause of death Myocardial infarction, fibrillation — Duration

Due to Arteriosclerotic H. disease

Due to Coronary occlusion (post.) acute

Other Conditions Pulmonary edema
Pleural effusion Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Beissinger M. D.
Address Sinai Hospital Date signed 10/26/46

937

PLEASE WRITE PLAINLY. Write on dotted lines. Do not abbreviate. Be sure to state the causes of death clearly and legibly. Do not report symptoms or modes of dying. Do not report conditions which did not contribute to the death. Omit items if not known. Be sure to answer all questions. Be sure to give correct age in each case. Physicians: please write the cause of death in your own words. Be sure to give correct age in each case. Physicians: please write the cause of death in your own words. Be sure to give correct age is especially important.

G44963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G44963
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G44961 BALTIMORE CITY HEALTH DEPARTMENT G44961
CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Roger Ave.
(c) Hospital or institution:
Methodist Home for the aged
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Roger Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah M. Ways

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Robert B. Ways
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1860

8. AGE: Years	Months	Days	If less than one day
86	8	29	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Mc Cord
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary E. Copper
15. Birthplace Virginia

16 (a) Informant Home for the Aged
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount and North Ave.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & P[illegible]. Aves.

19 (Date rec'd by registrar) OCT 28 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 19 46, at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1- 1946 to Oct 25 1946, and that I last saw HER alive on Oct 25 1946

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur J. Davis M. D.
Address 800 N 33rd St Date signed 10-26-46

Lexington Williams, M.D.

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

CERTIFICATE CORRECTED [redacted] G41965

BALTIMORE CITY HEALTH DEPARTMENT

G41965 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Bantalon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no

3 (a) FULL NAME Carl Alexander (Meyer) Meyer

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-03-734

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mrs. Christian Meyer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 21, 1877
8. AGE: Years 69 Months 7 Days 4 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business A. K. Robbins & Co.

FATHER 12. Name Mr. Christian (Meyer) Meyer
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Thiel
15. Birthplace Maryland

16 (a) Informant Hosp. Records
(b) Address Union Mem. Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) OCT 28 1946 (Date rec'd by registrar) Huntington Williams Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1946 at 4 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1946, to Oct. 24 1946, and that I last saw h[illegible] alive on Oct. 24 1946.

Immediate cause of death	Duration
Coronary Thrombosis	45 days
Due to Arteriosclerotic Heart Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas H. Johnson M.D.
Address 614 W. Date signed 10-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 190

X

G44966 BALTIMORE CITY HEALTH DEPARTMENT G44966
CERTIFICATE OF DEATH 1319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Callow Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Callow Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILY O. RANFT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis P. Ranft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1870

8. AGE: Years	Months	Days	If less than one day
75	10	7	hr. min.

9. Birthplace Wye Island, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ephriam B. Van Dyke
13. Birthplace Del.

MOTHER
14. Maiden Name Mollie Shamm
15. Birthplace Md.

16 (a) Informant Mrs. Roger Bell Ryan
(b) Address 5815 Royal Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 28 1946 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1946, at 5:47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct. 25 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
UREMIA, ACUTE	3 DAYS
Due to NEPHRITIS,	3 WEEKS
HYPERTENSION	
Due to ARTERIOSCLEROSIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C W Hoffman M.D.
Address 8 East Read St Date signed 10/26/46 M. D.

Huntington Williams, M.D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G44967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

~~G44967~~

Please write the causes of death clearly and legibly. Physicians: please write in the space provided. Information must be complete and correct as is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Orem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Orem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH JACOB

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1856

8. AGE: Years	Months	Days	If less than one day
90	7	3	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Peter Yinger
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Mr. Charles F. Jacob
(b) Address 6301 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 28 1946 (Date rec'd by registrar) (b)

Burlington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1946 to Oct 25 1946 and that I last saw h[er] alive on Oct 25 1946

Immediate cause of death	Duration
Uremia	2 days
Due to Chronic Interstitial Nephritis	5 years
Due to General Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hilbert F. Hillerman M.D.
Address 6 East Biddle St Date signed 10/28/46

X

G44968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
Twilight Nursing Home 70
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2675 Eagle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Reamer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Frank C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1868

8. AGE: Years	Months	Days	If less than one day
78	6	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James L. Daugherty
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Annie Booze
15. Birthplace Nova Scotia

16 (a) Informant Mrs. Annie Sullivan
(b) Address 2675 Eagle St.

17 (a) Burial (b) Date thereof 10/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address OCT 28 1946 Northern Pennsylvania Aves

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1946, at M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelly M.D.
Medical Examiner
Date signed 27 Oct 46

10-G44969

BALTIMORE CITY HEALTH DEPARTMENT X 55E

CERTIFICATE OF DEATH

G44969 Registered No.

Please write the causes of death clearly and legibly. Physicians; please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES ELIZABETH POTEE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W. C.	Married

6 (b) Name of husband or wife Richard Potee
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 4-11-07

8. AGE: Years	Months	Days	If less than one day
39	6	15	hr. min.

9. Birthplace Md. (Odenton) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Turner
13. Birthplace Md. (Odenton)

MOTHER
14. Maiden Name Hattie Jones
15. Birthplace Md. (Odenton)

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery or crematory Episcopal Ch. Cem.
Location Odenton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 28 1946 (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1946, at 7 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1946 to 10-26 1946 and that I last saw h alive on Oct 26 1946. Immediate cause of death Carcinomatosis, undetermined

	Duration
Due to Carcinoma, undetermined origin	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund R. Novak M. D.
Address Johns Hopkins Hosp. Date signed 10-26-46

G41970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

G41970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. If any item is unknown, write the word "unknown." Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER
(c) Hospital or institution: ST JOSEPHS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County B
(c) City or town BALTO. MD
3 E. North Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. TUDOR ARMS APT. 10 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM G. SMITHER (William Gouldman Smither)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex MALE
5. Color or race White
6 (a) Single, married, widowed, or divorced SINGLE
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 11-17-99
8. AGE: Years 46 Months 11 Days 18 If less than one day hr. min.
9. Birthplace RICHMOND, VA. (Town, county and state)
10. Usual Occupation NONE
11. Industry or business "

FATHER
12. Name Chas. W. Smither
13. Birthplace Hampton-Va.

MOTHER
14. Maiden Name Blanche Clay
15. Birthplace Amelia-Va.

16 (a) Informant Mrs. Alfred Hurley
(b) Address Tudor Arms Apt-City
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.
18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (H. F. BODDEN SUC.) 100 W. NORTH AVENUE
19 (a) (b) Huntington Williams, MD

OCT 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1946, at 7:35 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 1946 to 10-25 1946, and that I last saw him alive on 10-25 1946.

Immediate cause of death: CARDIO-RESP. FAILURE — Duration
Due to PORTAL CIRRHOSIS
ASCITES, CACHEXIA
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 10-20-46
Major findings of operation: NODULAR CIRRHOTIC LIVER
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Wells
Address St Joe Hosp Date signed 10-25-46 (M. D.)

X

G44971 D.C. g-60182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16 1a

G44971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill all blanks. Give the causes of death clearly and legibly. Physicians: please write the correct age in years, months, days, or hours. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street, 25
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hr. 50 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 25, (If outside city or town limits, write RURAL and give town)
(d) Street No. 961 Stoll St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country No.

3 (a) FULL NAME Baby Girl Becker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/24/46

8. AGE: Years	Months	Days	If less than one day
			6 hr. 50 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Edward J. Becker.
13. Birthplace

MOTHER
14. Maiden Name Mary L.
15. Birthplace

16 (a) Informant MR. ED. BECKER.
(b) Address 961 STOLL ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-46 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD,
Location CITY

18 (a) Funeral director WIEDEFELD & SON.
(b) Address GREENMOUNT. & 22ND ST.

OCT 28 1946 (b) (Date received by Registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1946 at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24/46 19 to 10/24/46 19, and that I last saw her alive on 10/24/46 19

Immediate cause of death Atelectasis. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry T. Wilson, Jr.
Address St. Joseph's Hosp. Date signed 10-25-46 M D

G44972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G44972 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 N. Stricker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Stricker St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? No years

3 (a) FULL NAME: Mattie Roe Holloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-2-1884

8. AGE: Years	Months	Days	If less than one day
62	3	25th	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER 12. Name Joseph Walker
13. Birthplace Va.

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Frank Walker Son in law
(b) Address Culpeper, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Culpeper, Va.

18 (a) Funeral director Charles C. Cooper
(b) Address 516-512 N. Carrollton Ave.

19 (a) (Date rec'd by registrar) (b) Williamsport, Md.

OCT 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946 at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1946, to 10/26/ 1946 and that I last saw h[illegible] alive on 10/24/ 1946.

Immediate cause of death	Duration
Coronary Thrombosis	10 Days
Due to Hypertensive Heart Disease	2 Months
Due to Arteriosclerosis	2 Months
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Bonham Hyson M. D.
Address 1773 Madison Ave. Date signed 10/29/46

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G44973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G44973

Registered No.

PLEASE WRITE PLAINLY, with unfading ink and write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 N.Fulton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Hall Smith

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov. 19th, 1900

8. AGE: Years	Months	Days	If less than one day
45	11	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Emory Hall
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Carrie Brown
15. Birthplace Calvert Co. Md.

16 (a) Informant Thomas Smith(Hus).
(b) Address 1022 N.Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto. County, Md.

18 (a) Funeral director Charles G.Cooper
(b) Address 510-512 Carrollton Ave

19 (a) OCT 28 1946 (Local registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25th 1946 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/-4 1946 to 10/25 1946 and that I last saw h[illegible] alive on 10/21-1946

Immediate cause of death

(a) Pneumonia

Due to Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 hrs
1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Hatch

Address 1775 Pentz Date signed 10/29/46

G44971 — BALTIMORE CITY HEALTH DEPARTMENT — G44971

CERTIFICATE OF DEATH ✓ 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry Items of information should be as nearly complete as possible. Write the causes of death clearly and legibly. Give correct age in especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 20 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Buchanan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Buchanan

3.(a) FULL NAME Mrs Laura E. Warner.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W.	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6. 1890

8. AGE: Years	Months	Days	If less than one day
56		18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER — 12. Name James E. Sullivan
13. Birthplace Md.

MOTHER — 14. Maiden Name Laura Hyde
15. Birthplace Md.

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Liberty Road

18 (a) Funeral director Marguette Downey
(b) Address 3615 Chestnut Ave.

19 (a) (Date received by registrar) (b) Registrar

OCT 28 1946 Huntington Williams, M.D.

VS Y50

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24, 1946 at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1946 to Oct 24 1946 and that I last saw h[illegible] alive on Oct 24 1946.

Immediate cause of death	Duration
Cardiac Collapse	
Due to Congestive heart failure	
Due to Coronary thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Agnate
Address Md. General Hosp. Date signed 10/24/46 M. D.

G41975 — BALTIMORE CITY HEALTH DEPARTMENT — G41975

CERTIFICATE OF DEATH 1318 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3617 Chestnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maynard L. Chenoweth Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Paul F. Chenoweth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9, 1890

8. AGE: Years 56 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses F. Oswald.
13. Birthplace Md.

MOTHER
14. Maiden Name Lee McCullough.
15. Birthplace Md.

16 (a) Informant Paul F. Chenoweth Jr
(b) Address 3615 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Gwynns Oak Ave.

18 (a) Funeral director Wesley F. McNamee
(b) Address 4114 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Willi[illegible]

OCT 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 1946 to 25 OCT. 1946, and that I last saw her alive on 25 OCT. 1946.

Immediate cause of death	Duration
Uremia	10 days
Cerebral hemorrhage	3 weeks
Due to Hemiplegia (Left)	
Due to Chronic Nephritis	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave. Date signed 27 Oct 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. Be sure the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G44976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G44976 100 B

Registered No. G44976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Ave
(c) Hospital or institution: West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 E. 24th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emily Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1889

8. AGE: Years	Months	Days	If less than one day
57 58	4	9	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Happy Hills Home

FATHER
12. Name Robert N. Ford
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Kelly
15. Birthplace Md

16 (a) Informant Robert N. Ford
(b) Address 414 N. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)

(c) Cemetery or crematory St. Mary's
Location Hampstead

18 (a) Funeral director Shurtleff & Forman
(b) Address 1615 Eastern Ave.

19 (a) (Date received by Registrar) OCT 28 1946

Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-46 19 ... at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1946 to 10-25 1946, and that I last saw her alive on 10-25 1946.

Immediate cause of death: Massive Pulmonary Embolism — Duration

Due to — Phlebo Thrombosis - left

Due to

Other Conditions - Ulcerative Colitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy - Pulmonary Embolus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Bernheim M.D.
Address West Baltimore Hospitals Date signed 10-25-46

X

Dr. Henry Haase
1218 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C21977

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Pinewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Pinewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Mildred Kiel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1943

8. AGE: Years	Months	Days	If less than one day
3	--	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Rowland O. Kiel
13. Birthplace Md.

MOTHER
14. Maiden Name Mildred A. Budde
15. Birthplace Md.

16 (a) Informant Mr. Rowland O. Kiel
(b) Address 3009 Pinewood Ave nue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road.

19 Huntington Williams, M.D. Registrar
OCT 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1946 at 9:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 to Oct. 1946 and that I last saw her alive on Oct. 25 1946

Immediate cause of death: Neuroblastoma (Retinoblastoma) right eye with Duration 11 mos.
Due to Multiple Metastases to skull + mandible
Other Conditions Extreme cachexia and anemia
(Include pregnancy within 3 months of death)
Date of operation January 1946
Major findings of operation Biopsy - at. eye removed.
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Haase
Address 1218 Harford Road Date signed Oct 28 '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. A very item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C44978 105406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. C44978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4527 Winfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Dawson

3 (b) If veteran, name war

3 (c) Social Security Account No. Single

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30/1905

8. AGE: Years	Months	Days	If less than one day
40	9	26	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name William Dawson
13. Birthplace Va.

MOTHER: 14. Maiden Name Lucy (R. Spangler
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-46 (month) (day) (year)
(c) Cemetery or crematory Moreland Cem.
Location Baltimore Md

18 (a) Funeral director Leonard J. Ryan
(b) Address 5305 Harford Rd

19 (a) OCT 28 1946 Registrar for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26th 1946; at 4.56 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 19/1946 to Oct/26/ 1946 and that I last saw alive on Oct. 26 1946

Immediate cause of death: Tuberculous meningitis — Duration 2 hrs.
Due to Pulmonary Tuberculosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt
Address Balt City Hosp. Date signed 10-26-46 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if none, write none. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G41379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G41379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 S. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Kinsley Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	

6 (b) Name of husband or wife Pearl Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1898

8. AGE: Years	Months	Days	If less than one day
48	6	13	hr. min.

9. Birthplace Suffolk Va
(Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Bill Jones
13. Birthplace Suffolk Va

MOTHER
14. Maiden Name Austin ?
15. Birthplace Suffolk Va

16 (a) Informant Pearl Jones
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 30, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Cleon D. Wilson
(b) Address 1000 Bentley ave

Oct 28 1946 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct-25 1946, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Coronary occlusion

Due to Arteriosclerosis, Generalized

Due to

Other Conditions Pulmonary emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund L. Dubois M. D.
Address Johns Hopkins Hospital Date signed Oct 25 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Write the word "None" where it is the correct answer. Ages should be stated in full, and the exact age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G41980 BALTIMORE CITY HEALTH DEPARTMENT G41980
CERTIFICATE OF DEATH 166 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane THOMAS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/3/1904

8. AGE: Years	Months	Days	If less than one day
42	3	21	hr. min.

9. Birthplace Smithville Stokesville Md
(Town, county, and state)
10. Usual Occupation DOMESTIC
11. Industry or business

FATHER 12. Name GEORGE MILTON
13. Birthplace MD.

MOTHER 14. Maiden Name MARY A. WADE
15. Birthplace MD

16 (a) Informant GEORGE MILTON
(b) Address 308 N. MOUNT ST
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory WESTERN STAR
Location
18 (a) Funeral director ELROY O. WILSON
(b) Address 1000 BRANTLY AVE
19 (a) OCT 28 1946 (Date received by registrar) (b) Huntington Williamsport, MD

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct. 24 1946, at 2:55 P.M.
21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Section of spinal cord by bullet.
Due to
Other Conditions Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 20-46 at 10:30 P. M.
(b) Where did injury occur? Harlem Theatre - 600 blk N. Gay St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms
23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/25/46

VS 191

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians please write.

G44981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G44981 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Atkins (nee Washington)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	black	married

6 (b) Name of husband or wife Lawrence Atkins
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 2-4-22

8. AGE: Years	Months	Days	If less than one day
24	2	19	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Edom Washington
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Clark
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Oct. 28 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Bryan Thomas & Knight
(b) Address 721 Presstman St

Oct 28 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1946, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1946 to 10-23 1946 and that I last saw h[illegible] alive on 10-23 1946

Immediate cause of death Tuberculous meningitis — Duration 1 week

Due to Tuberculous peritonitis — 5 weeks

Due to

Other Conditions Tuberculous pleurisy — ?

(Include pregnancy within 3 months of death)

Date of operation 9/23/46

Major findings of operation: Tuberculous peritonitis

of autopsy: Tuberculous meningitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Nate Long
Address Johns Hopkins Hosp Date signed 10/28/46 M. D.

VS 150

G44982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G44982 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 440 East 23d Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 440 East 23d Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Walter Sylvester Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex 68 M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Estelle Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1878

8. AGE: Years	Months	Days	If less than one day
67 68	10	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Andrew Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Timms
15. Birthplace Annapolis, Md

16 (a) Informant wife - Mrs Estelle Jackson
(b) Address 440 E. 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mr. Francis A. Hensley
(b) Address 578 W. Biddle St

19 (a) 28 1946 (Date registered) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946, at 2:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1946 to 10/26 1946 and that I last saw h[illegible] alive on 10/25 1946.

Immediate cause of death: Cardio-Vascular-Renal disease — Duration: Several years

Due to

Due to

Other Conditions Contributory — Two

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Slaughter M.D.
Address 825 N. Fremont Ave Date signed 10/28/46

G41983 BG# G57194 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH V157E Registered No. G41983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: So. Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lifelong
(e) Length of stay in Baltimore (yrs., mos., or days) Lifelong

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give township)
(d) Street No. 508 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Duane

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-46

8. AGE: Years | Months | Days: 0 | If less than one day Lwyths. hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER:
12. Name Robert J. Duane
13. Birthplace Maryland

MOTHER:
14. Maiden Name Edna Taylor
15. Birthplace W. Va.

16 (a) Informant Mr. Robert J. Duane
(b) Address 508 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd.

18 (a) Funeral director John J. Denny Inc.
(b) Address 716 Light St.

19 (a) (b) Washington Williamsport, Md.
(Date received) 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1946 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1946 to 10-26 1946 and that I last saw h/ alive on 10-26 1946

Immediate cause of death
(a) Uremia
Due to Pyelonephritis
(b) Due to
Other Conditions Pyelonephritis Stenosis
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

Date of operation 10-25-46
Major findings of operations Pyelonephritis Stenosis
of autopsy Pyelonephritis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Stephen Greenfield M. D.
Address 121 Light St. Date signed 10-26-46

VS 150

G44984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/186a

Registered No. G44984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 South Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 South Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA G. GOODWIN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Fines L. Goodwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 14, 1865

8. AGE: Years	Months	Days	If less than one day
81	3	11	hr. min.

9. Birthplace: Iowa (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Elias Keach
13. Birthplace: unknown

MOTHER
14. Maiden Name: Mary McNeil
15. Birthplace: unknown

16 (a) Informant: Mr. F. Lee Goodwin, Jr.
(b) Address: Boyce Ave. & Overbrook Rd. Ruxton 4, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1946 to Oct. 25 1946 and that I last saw her alive on Oct. 25 1946.

Immediate cause of death	Duration
Pulmonary Edema	3 Days
Due to Broncho-Pneumonia	7 days
Due to	
Other Conditions Fracture Shoulder 13 da.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Accident
(a) Accident, suicide, or homicide
(b) Date of occurrence 10-12-46 at 6:30 P M
(c) Where did injury occur? 2205 South Road (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? N/A
(e) Means of injury Slipped on rug and fell to floor

23. Signature Sherman R. Harris M. D.
Address 24 01 Manhattan Ave. Date signed 10/26/46

Huntington Williams, M.D. Howard J. Curtis, M. D.

AB- 82 G44985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G44985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs- 3mo- 20days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 1/2yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Oehm

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Theresa (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10- 1888

8. AGE: Years	Months	Days	If less than one day
58	6	17	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Francis F. Oehm (D
13. Birthplace Va.

MOTHER
14. Maiden Name Ann Bonad (D
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Fallsway

19 (a) OCT 28 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1946, at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7- 1943, to 10-27 1946, and that I last saw him alive on 10-27 1946.

Immediate cause of death: Coronary Occlusion — Duration
Due to Arteriosclerosis Coronary
Due to
Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice M. Lacy M. D.
Address Baltimore City Hospitals Date signed 10-27-46

94a

G44986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registration No. G44986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 S. Stricker St
(c) Hospital or institution:
19-B
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 S. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah R. Fullenkamp

3 (b) If veteran, name war ———— | 3 (c) Social Security Account No. ————

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Charles B. Fullenkamp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10th. 1898

8. AGE: Years	Months	Days	If less than one day
48	4	16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

MOTHER | FATHER
12. Name Willian F. Smardon
13. Birthplace Baltimore Md.
14. Maiden Name Sarah E. James
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Charles B. Fullenkamp
(b) Address 234 S. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30th. 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director Leo L Berger Jr
(b) Address 1512 Hollins St.

19 (a) [illegible] (b) Huntington Williams Mch 8 Registrar
OCT 28 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1946 to Oct 26 1946 and that I last saw h[illegible] alive on Oct 26 1946.

Immediate cause of death — Duration
Uremia or a toxemia + encephalopathy. 10 days
Due to Cirrhosis of Liver. 4 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Bruce Woodbood M. D.
Address 2200 Garrison Blvd Date signed 10/28/46

G14987 BALTIMORE CITY HEALTH DEPARTMENT G14987
CERTIFICATE OF DEATH
Registered No. 121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Kenwood Ave, Catonsville, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. William Henry Denney

3 (b) If veteran, name war —

3 (c) Social Security Account No. 117-01-4203

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Widowed

6 (b) Name of husband or wife Minnie E. Denney.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1874.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	—	9		

9. Birthplace Orange Essex Co., New Jersey. (Town or county and state)
10. Usual Occupation Retired Painter
11. Industry or business Advertising

FATHER
12. Name Deceased John H. Denney
13. Birthplace Unknown

MOTHER
14. Maiden Name deceased
15. Birthplace Unknown

16 (a) Informant Mrs. Dorothy Edge.
(b) Address Kenwood Ave. Catonsville.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46. (month) (day) (year)
(c) Cemetery or crematory Rosedale Cemetery
Location Montclair, New Jersey.

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave. Catonsville

(a) OCT 28 1946 (b) Huntington Williams, M.D.
(Date received) (Signature of local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1946, at 1 49 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1946, to 10-26 1946, and that I last saw h[illegible] alive on 10-26 1946.

Immediate cause of death: Cerebral Hemorrhage
Due to Chronic nephritis with Hypertension
Due to
Other Conditions Cerebral arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Chronic nephritis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollyes M. D.
Address St Agnes Hospital Date signed 10-26 X 1946

G44988 | BALTIMORE CITY HEALTH DEPARTMENT | G44988

CERTIFICATE OF DEATH

1866 | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Menlo Drive (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Bertram L. Keyes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Bertram L. Keyes | 6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1883

8. AGE: Years 63 | Months 1 | Days 14 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Architect
11. Industry or business

FATHER
12. Name James Keyes
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice McGill Haskell
15. Birthplace Baltimore, Md.

16 (a) Informant: Hospital Records
(b) Address Union Mem. Hosp., Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Lorenz Byers
(b) Address 5005 Park Heights Ave

19 (a) Registered OCT 28 1946 Registrar
Transcription for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1946 at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1946 to Oct. 27 1946 and that I last saw him alive on Oct. 26 1946.

Immediate cause of death	Duration
Pulmonary Embolism	11 days
Due to Thrombophlebitis right leg.	2 weeks
Due to Fracture right ankle.	1 mth 2 days
Other Conditions Uremia acute cor pulmonale (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9-30 at 10 A M
(c) Where did injury occur Taylor & Dickey, 1012 N. (City or town) (County) Cal. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial (Specify type of place) While at work? Yes
(e) Means of injury [illegible]

23. Signature Norman R. Freeman M. D.
Address Union Memorial Hospital Date signed Oct 29, 46

G44989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G44989

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 S. Franklintown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 S. Franklintown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel W. Kolb

3 (b) If veteran, name war None

3 (c) Social Security Account No. 213-10-0095

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary R. Kolb

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May 15. 1873

8. AGE: Years 73 Months 5 Days 10 If less than one day hr. min.

9. Birthplace Frederick Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

MOTHER / FATHER

12. Name Samuel W. Kolb

13. Birthplace Md

14. Maiden Name Mary J. —

15. Birthplace Md

16 (a) Informant Mary R. Kolb

(b) Address 146 S. Franklintown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29. 1946 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn Md

18 (a) Funeral Director Roll & B. M. Walters

(b) Address Pratt & Stricker Sts

19 (a) (b) Huntington Millington Md

OCT 28 1946

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25- 1946, at 11. AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Oct 25 1946, and that I last saw him alive on Oct 25 1946

	Duration
Immediate cause of death: Cerebral Hemorrhage	6 wks.
Due to Hypertension	1 yr.
Due to Generalized arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B. Schreiber M. D.
Address 54 S. Fulton Ave Date signed 10-26-46

G44990 BALTIMORE CITY HEALTH DEPARTMENT G44990
CERTIFICATE OF DEATH 53 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2770 Ellicott Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2770 Ellicott Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas B. Nelson

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 705-10-9810
4 Sex: Male
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Martha U. Corl
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 15-1887
8. AGE: Years 59 Months 6 Days 17 If less than one day hr. min.
9. Birthplace Virginia (Town, county, or state)
10. Usual Occupation Retired Conductor
11. Industry or business B.&O.R.R.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Candis Black
15. Birthplace Virginia

16 (a) Informant Martha U. Nelson
(b) Address 2770 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30-1946 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Jessup Md
18 (a) Funeral director Pratt C. B. M. Walters
(b) Address Pratt & Strucker Sts
19 (a) (Date received by registrar) OCT 28 1946 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH October 27 1946, at 1.53 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30-46 19 to Oct 27-46 19 and that I last saw h[illegible] alive on Oct 17-46 19
Immediate cause of death: Duration
(a) Insufficiency of Pericardial
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry E. Strodel
Address 2703 Edmondson Date signed 10-27-46

VS 150

G44991 BALTIMORE CITY HEALTH DEPARTMENT G44991
CERTIFICATE OF DEATH
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 269 Colgate Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Kurtz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Jessie Kurtz
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) May 17 1880

8. AGE: Years	Months	Days	If less than one day
66	5	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business /

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Nolting
15. Birthplace Maryland

16 (a) Informant Jessie Kurtz
(b) Address 269 Colgate Ave
17 (a) Burial (b) Date thereof Oct 29
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural
18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St
19 (a) E. Huntington Williams, M.D.
Registrar
OCT 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1946, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1946, to 10-25 1946, and that I last saw him alive on 10-25 1946.

Immediate cause of death Cerebral embolism
accident — Duration

Due to

Due to

Other Conditions Bronchogenic Carcinoma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Bronchogenic carcinoma

of autopsy: Postmortem statement right

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Crouch M. D.
Address University Hosp. Date signed 10-26-46

VS 150

X

G44992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G44992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 3014 Northern Pkway
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Sause

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Sause
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Aug 16 1866

8. AGE: Years	Months	Days	If less than one day
81	2	8	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Retired

BUSINESS FATHER
12. Name Henry Sause
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Gehse
15. Birthplace Germany

16 (a) Informant Henry Sause
(b) Address 1657 Argyle Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Allendale St

19 (a) (Date rec'd by registrar) (b) Burial Permit

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946 at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1946 to Oct. 26 1946 and that I last saw him alive on Oct. 25, 1946.

Immediate cause of death Carcinoma of prostate — Duration 1 yr.
Due to Generalized metastases.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Harold A. Scott M. D.
Address 4100 Harford Rd Date signed 10/26/46

VS 1M OCT 28 1946

Huntington Press

X

G44993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G44993 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 W. Lee St
(c) Hospital or institution:
2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Diegel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank Diegel
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/10/1857

8. AGE: Years 87 | Months 8 | Days 16 | If less than one day ___ hr. ___ min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Henry Moser
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Lesser
15. Birthplace Germany

16 (a) Informant Henry Diegel
(b) Address 11 W. Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem Co
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 210 E Orleans St

19 (a) OCT 28 1946 (b) [illegible]
(City or town) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1946, to 10/26 1946 and that I last saw h[illegible] alive on 10/25 1946

Immediate cause of death Pulmonary Edema associated with cardiac failure — Duration 3 days

Due to Cardiovascular Disease 7

Due to —

Other Conditions General & cerebral arterio sclerosis 21

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Diegel
Address 1116 Hanover St Date signed 10/29/46

Awaiting for Autopsy

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B Cth 65730 159 ✓ G11291 G11291

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Linnard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Rott Rott

3 (b) **If veteran, name war** | (c) **Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/25/46

8. AGE: Years	Months	Days	If less than one day
0	1	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Bernard Rott
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Daddy
15. Birthplace Maryland

16 (a) Informant Bernard Rott
(b) Address 1364 Bouldin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem Co.
Location

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2208 Arlington Ave

19 OCT 28 1946 (b) Katherine Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1946, at 9:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1946 to 10/27 1946, and that I last saw h.IS alive on 10/27 1946

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin W. Kemp M.D.
Address Md. Gen. Hosp. Date signed 10/27/46

VS 150

G44995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G44995 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The report age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Eaton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Jenkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6. (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 1869

8. AGE: Years 79 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Longview Maryland
(Town, county, state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Jenkins
13. Birthplace Md

MOTHER 14. Maiden Name Alice Shaw
15. Birthplace Md

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1946 (month) (day) (year)
(c) Cemetery or crematory St Johns Long Green Valley Md
Location Balto Co Md

18 (a) Funeral director Henry W Jenkins Sons
(b) Address N Caroll & Orchard St

28 1946 (Date filed by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946 at 9.03 P M

21. I certify that death occurred on the date above stated that I attended deceased from April 1 1946 to Oct 26 1946 and that I last saw her alive on Oct 26 1946.

Immediate cause of death: Cardiac Failure — Duration

Due to Acute Cardiac Dilatation

Due to Arteriosclerotic Heart Disease

Other Conditions Carcinoma Breast [illegible] amputated
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. Dalgliesh M. D.
Address St. Agnes Hosp. Date signed 10-26-46

VS 150

G44996 BALTIMORE CITY HEALTH DEPARTMENT G44996

CERTIFICATE OF DEATH

Registered No. 1242

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Uppers (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Doris Cameron Caplis

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1946

8. AGE: Years	Months	Days	If less than one day
		23	hr. min.

9. Birthplace Balto City (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Vincent T. Caplis
13. Birthplace Md.

MOTHER 14. Maiden Name Doris M. Tracey
15. Birthplace Md.

16 (a) Informant Vincent T Caplis
(b) Address Reisterstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto. Co.

18 (a) Funeral director Edw. L Tipton
(b) Address Hampstead Md.

(a) Date received 1946 (b) by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Oct 1946; at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Oct 1946 to 27 Oct 1946 and that I last saw h[illegible] alive on 27 Oct 1946.

Immediate cause of death: Bilateral Cerebral

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. S. Bauer M. D.
Address Univ. Hosp Date signed 28 Oct 46

G44997

BALTIMORE CITY HEALTH DEPARTMENT ✓ G44997

Registered No.

TB. 104719

CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-month & 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7th 1913

8. AGE: Years	Months	Days	If less than one day
33	0	21	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation male nurse
11. Industry or business

FATHER
12. Name Fred Allen
13. Birthplace New Jersey

MOTHER
14. Maiden Name Alice
15. Birthplace New Jersey

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (records

17 (a) removal (b) Date thereof 10-28-46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory
Location Newark N.J.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1600 Eutaw Place

19 (a) Huntington Williams
(Date rec'd by registrar) (Signature of registrar)

OCT 29 1946

MEDICAL CERTIFICATION A

28. DATE OF DEATH Oct 28/ 1946 at 8.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept.23/ 1946 to Oct /28 1946 and that I last saw him alive on Oct 28/46 1946

Immediate cause of death Pulmonary Tuberculosis, Far advanced — Duration 7 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph A Bird
Address Balto City Hosps Date signed 10/28/46 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G41998 BALTIMORE CITY HEALTH DEPARTMENT G41998
CERTIFICATE OF DEATH 51B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Strawbridge
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/27/1867
8. AGE: Years 79 Months 4 Days 1 If less than one day hr. min.
9. Birthplace Harford Co Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business
FATHER 12. Name Joseph Strawbridge
13. Birthplace Harford Co Md
MOTHER 14. Maiden Name Sara Myers
15. Birthplace Penna
16 (a) Informant Mildred Strawbridge
(b) Address 1425 Londonview
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-46 (month) (day) (year)
(c) Cemetery or crematory Center Cemet
Location New Park Pa
18 (a) Funeral director H. Howard Shelf
(b) Address Hayes Grove Pa
19 (Date rec'd by registrar) OCT 29 1946 Huntington Williamson, M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH 10-28 1946, at 8:35 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1946, to 10-28 1946, and that I last saw him alive on 10-28 1946.
Immediate cause of death: Respiratory failure
Due to: Hypertensive cardiovascular disease
Due to:
Other Conditions: Carcinoma of prostate
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Walter K. Crouch M. D.
Address University Hospital Date signed 10-28-46

VS 180

G44999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G44999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Govtn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7711 Braddock Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander B. Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Susan Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 17th 1876

8. AGE: Years: 70 Months: - Days: 10 If less than one day: hr. min.

9. Birthplace: Dunn N. C. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Grocery

FATHER
12. Name: George Washington Fowler
13. Birthplace: Dunn N. C.

MOTHER
14. Maiden Name: Ferbie
15. Birthplace: Dunn N. C.

16 (a) Informant: Rosalie Bukovsky
(b) Address: 7711 Braddock Ave - Govtn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/30/46 (month) (day) (year)
(c) Cemetery: Woodlawn
Location: " Md.

18 (a) Funeral director: Wm Cook Inc
(b) Address: 6367 St. Paul St

19 (a) OCT 29 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27th 1946, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1946 to Oct 27 1946 and that I last saw him alive on Oct. 27 1946

Immediate cause of death: MYOCARDITIS — Duration: 5 yrs.

Due to: ARTERIOSCLEROSIS — 10 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Norman R. Klemm M.D.

Address: 3803 Edmondson Date signed: 10/28/46

G15000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

✓ G15000 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4012 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4012 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William T. Brooks

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Clara Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1866

8. AGE: Years 80 Months — Days 24 If less than one day hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William J. Brooks
13. Birthplace Md

MOTHER
14. Maiden Name Hepsah Leitsinger
15. Birthplace Md

16 (a) Informant Clara Brooks
(b) Address 4012 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Gilbert Funeral Home
(b) Address 1219 Park Ave

19 (Date received by registrar) Huntington Wills

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1946 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1946 to Oct 27 1946, and that I last saw him alive on Oct 27 1946.

Immediate cause of death: Cardiac decompensation — Duration 3 hrs
Due to Cardio-vascular-renal disease. — 5 yrs
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Brewer
Address 846 W 36 St Date signed 10/28/46

VS 150

G15001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G15001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 N Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 N Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William A Seabrease

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1866

8. AGE: Years 80 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Baltimore Transit Co

FATHER 12. Name Henry Seabrease

13. Birthplace Md

MOTHER 14. Maiden Name Unknown

15. Birthplace Md

16 (a) Informant Grace Schmidt

(b) Address 1203 N Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)

(c) Cemetery or crematory Balto

Location Md

18 (a) Funeral director Wilson Son & Lee

(b) Address 1914 Pont St

19 (a) Date received 10-29-1946 (b) Registrar Wilmington Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1946, at 5:30 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 24, 1946 to Oct. 28, 1946 and that I last saw him alive on Oct. 28, 1946.

Immediate cause of death	Duration
Coronary occlusion	4 days.
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wallace G Dingwall M. D.

Address 1613 E North Ave Date signed 10-29-46

Correct Age if impossibly high—Typewriting—Physicians, please write plainly. Give the causes of death clearly and legibly.

G45002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G45002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Sidney Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2101 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emelia C Huber

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Edward
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 6 1894

8. AGE: Years	Months	Days	If less than one day
52	2	21	hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Philip Doetter
13. Birthplace: Md

MOTHER
14. Maiden Name: Julia Messinger
15. Birthplace: Germany

16 (a) Informant: Edward Huber
(b) Address: 2101 Sidney Ave

17 (a) Final disposition (Burial, cremation, or removal): Interred (b) Date thereof (month) (day) (year): 10/29/46
(c) Cemetery or crematory: Glen Haven
Location: Glen Burnie Md

18 (a) Funeral director: Wilson & Son
(b) Address: 1219 Eutaw St

19 (a) Date received by registrar: OCT 29 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1946, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1946 to Oct 27 1946, and that I last saw h[er] alive on Oct 26 1946.

Immediate cause of death	Duration
a Generation uremia	1 week
Due to carcinoma, metastatic	4 months
Due to from carcinoma of uterus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 1946
Major findings of operation: metastatic carcinoma, ruptured uteri
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosman
Address 206 S. Gilmor St. Date signed 10-28-46 (M. D.)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45003 Ed.

BALTIMORE CITY HEALTH DEPARTMENT

105044 CERTIFICATE OF DEATH ✓467

Registered No. G45003

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Buck

3 (b) If veteran, name war —
3 (c) Social Security Account No. [illegible]

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19th 1891

8. AGE: Years 54 | Months 11 10 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Buck
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Wenderoth
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 OCT 29 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28th /1946 at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15th 1946 to Oct 28 1946 and that I last saw him alive on Oct 28 1946

Immediate cause of death: Carcinoma of Rectum — Duration

Due to

Due to

Other Conditions Carcinomatosis metastatic
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: Absent.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maureen M. Lacy, M. D.
Address Baltimore City Hosp Date signed 10-28-46

X

G15004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1436

Registered No. G15004

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3423 Sinclair Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillie M. Mitchell

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband Raymon Wilbur Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/73

8. AGE: Years	Months	Days	If less than one day
73	0	5	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Sidney B Fickler
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary A. Thurston
15. Birthplace "

16 (a) Informant Sidney L Mitchell
(b) Address 4107 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 29 1946 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946, at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1946 to 10/28 1946 and that I last saw her alive on 10/27/1946.

Immediate cause of death	Duration
Cardiorespiratory Failure	
Due to Cerebral Thrombosis	
Due to Thrombophlebitis	
Other Conditions Thrombosed Prolapsed Ext. Hemorrhoids (Include pregnancy within 3 months of death)	

Date of operation 10/7/1946
Major findings of operation: Thrombosed Prolapsed Hemorrhoids
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 10/28/46 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45005 Reg. No. 97793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G45005 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-months & 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Padgett

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23/1867

8. AGE: Years 79 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William B. Boggess; 13. Birthplace Maryland

MOTHER — 14. Maiden Name Mercelina Wright; 15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Oliver & Greenmount Ave

18 (a) Funeral director Wm. J. Cook Co.
(b) Address 127 N. St Paul Street

19 (a) [illegible] (b) Huntington Williams, M.D.

OCT 29 1946

VS 190

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct 26/46 19 at 1.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10/ 1945 to Oct 26/ 1946 and that I last saw her alive on Oct 26/ 1946

Immediate cause of death: Cardiac failure — Duration: unstated

Due to: Degeneration of Coronary Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Cardiac Decompensation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M.D.
Address Bal City Dept. Date signed 10/29/46

X

G35006 BC# B58918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G35006 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laury

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 1946

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul Laury
13. Birthplace New York

MOTHER
14. Maiden Name Margaret Lipscomb
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Destroyed by Hospital

18 (a) Funeral director
(b) Address

(a) Date received by Registrar OCT 29 1946 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1946 to Oct. 13 1946 and that I last saw h er alive on Oct. 13 1946

Immediate cause of death Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address Johns Hopkins Hospital Date signed 10-15-46

X

G45007 OC# 59636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45007 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Sollers Point Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cowger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1946

8. AGE: Years	Months	Days	If less than one day
			2 hr. 25 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul Cowger
13. Birthplace West Virginia

MOTHER
14. Maiden Name Ruby Starks
15. Birthplace West Virginia

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

OCT 29 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1946, at 3:02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946 to Oct. 16 1946, and that I last saw her alive on Oct. 16 1946.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address Johns Hopkins Hospital Date signed 10-18-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45008

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 Fait Ave.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Felix Wierzynske

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-3330

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife (Emilia) Mollie Wierzynske

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Floor plaster

11. Industry or business Plastering Bricklaying

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Mollie
15. Birthplace Poland

16 (a) Informant Emilia Mollie Wierzynske
(b) Address 2615 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31, 46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary (Co.
Location Gunpowder Hill Road

18 (a) Funeral director Michael E. Crawford
(b) Address 1000 S. Kenwood Ave.

Oct 29 1946 (Date received by Local Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946 at 5 Day M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946 to Oct 28 1946. and that I last saw h[illegible] alive on Oct 27 1946

Immediate cause of death: Hypostatic Cardio Vascular Renal Cardiac Insufficiency

Duration: Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunter Williams M. D.

Address 20 E. 39 Extn. Date signed

X

G15009 B.L.J. 60570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1160a

G15009 Registered No.

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr. 50 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. — 1828 Jackson St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Gordon (Boy)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 26 Oct 1946

8. AGE: Years	Months	Days	If less than one day
—	—	—	12 hr. 50 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name K V Gordon
13. Birthplace Copland, Md

MOTHER
14. Maiden Name Frances Norris
15. Birthplace Knoxville, Md.

16 (a) Informant Frances Gordon
(b) Address 1828 Jackson St, Balto, Md.

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory Location University Medical School OCT 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address ____

OCT 29 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Oct 1946, at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Oct 1946, to 27 Oct 1946, and that I last saw him alive on 27 Oct 1946.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to ____

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature [illegible] M. D.
Address Franklin Sq Hospital Date signed X

C45010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C45010

AB-105313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Beltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 75?

8. AGE: Years	Months	Days	If less than one day
75?	?	?	hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address
(c) (Date rec'd by registrar) Huntington Hillsmeyer

OCT 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1946, at 8.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1946 to 10-17 1946, and that I last saw h im alive on 10-17 1946.

Immediate cause of death
757 Respiratory failure
Due to Evacuation & starvation
Bronchopneumonia
Due to
Other Conditions Hemiplegia, right
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Doyle Walton M. D.
Address B C H Date signed 10/29/46

G15011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CHK-105287 13 B

G15011 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Greenmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evans Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14-1881

8. AGE: Years	Months	Days	If less than one day
65	9	3	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Jones
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Jane ?
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 29 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH October 17 1946 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946 to Oct. 17 1946. and that I last saw h im alive on Oct. 17 1946

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration 6 yrs.

Due to

Due to

Other Conditions Chronic Alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 10-26-46

VS 150

G15012 BC# B60001

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 161a

G15012
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County St. Mary's
(c) City or town Park Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. Snow Hill Manor Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 22, 1946

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Walter Ralph Clark
13. Birthplace

MOTHER
14. Maiden Name Katherine Singer
15. Birthplace Montana

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 29 1946
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1946 at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1946 to Oct. 24 1946 and that I last saw him alive on Oct. 24 1946

Immediate cause of death: Atelectasis, massive bilateral — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 10-24-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45013 No. 103123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months & 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3421 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles William Theis

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife X
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15/1931

8. AGE: Years	Months	Days	If less than one day
15	2	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Phillip Theis
13. Birthplace Germany

MOTHER
14. Maiden Name Julie Werlaski
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26/1946 at 5.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1946 to Oct 26/ 1946 and that I last saw him alive on Oct /26 1946

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration 14

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hosp. Date signed 10-28-46 M.D.

X

G15014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G15014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison Street
(c) Hospital or institution:
Crawford Retreat Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 E. Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD FOXWELL BACON

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-22-5464

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife: X
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1883

8. AGE: Years	Months	Days	If less than one day
63	4 5	12	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Edward L. Bacon
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Jenny B. Foxwell
15. Birthplace St. Mary's Co., Md.

16 (a) Informant Mr. Walter E. Bacon- Bro.
(b) Address 1804 E. Lafayette Street

17 (a) Burial (b) Date thereof 10-30-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) (b) Huntington Ave. Baltimore, Md.

OCT 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946 5.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Oct 26 1946, and that I last saw h[illegible] alive on Oct 26 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Strickhouser M. D.
Address 202 Edgevale Rd Date signed 10/29/46

Strickhouser

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC 5 G59029

TH. G45015 104901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G45015

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Mount Mory Court
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brooks (Louise)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29th 1946

8. AGE: Years	Months	Days	If less than one day
		26	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Henry Brooks
13. Birthplace New York

MOTHER
14. Maiden Name Louise Elizabeth
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 29 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25/ 1946, at 4.58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept /29 1946 to Oct 25 1946 and that I last saw h e r alive on Oct 25 1946

Immediate cause of death: Dehydration, malnutrition, sepsis — Duration 5 days

Due to diarrhea — Duration months

Due to Prematurity — Duration life

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Oct 29 '46

X

G15015 Birth Certificate G-# 64765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G15016 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 B Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3.(a) FULL NAME Baby Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/24/46

8. AGE: Years	Months	Days	If less than one day
—	—	—	7 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joe Anderson
13. Birthplace Roanoke, Va

MOTHER 14. Maiden Name Anderson, E.
15. Birthplace Newport, Va

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location University Medical School OCT 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 29 1946 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24th 1946. at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23rd 1946. to 10/24th 1946. and that I last saw h[illegible] alive on 10/24th 1946.

Immediate cause of death

Atelectasis — Duration 6 hr.

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzales M.D.
Address M. General Asylum Date signed 10/29/46

X

G15017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HB# 104252

Registered No. G15017

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 10/1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 24
(e) Length of stay in Baltimore (yrs., mos., or days) 85 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 N. Central Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Busch

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1861

8. AGE: Years	Months	Days	If less than one day
85	1	15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Lawrence Busch
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Kohler
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 OCT 29 1946 (Date received by Registrar) Huntington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1946, 9 (1 PM)

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1946 to Oct. 29 46. and that I last saw h er alive on Oct. 27 1946.

Immediate cause of death: Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions Intertrochanteric Fracture, Rt. femur.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence About 8-31-46 at Unknown
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Unknown While at work?
(Specify type of place)
(e) Means of injury Unknown (Supposed to have fallen

23. Signature Marion M. Levy M. D.
Address Baltimore City Hosps Date signed 10-29-46

To Be Approved by the Medical Examiner
for S. Wm Ramsey, by Howard J. Andersen, M.D.

3133 G15018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G15018 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 715
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Fredrick St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Mayo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - - - 1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
29	6			

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Morris Mayo
13. Birthplace South Carolina

MOTHER
14. Maiden Name Ella Simons
15. Birthplace South Carolina

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 3. 1946 (month) (day) (year)
(c) Cemetery or crematory St Matthews Church
Location Wagsboro S.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Baltimore ave

19 (a) [illegible] 30 1946 (Date received by registrar) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1946, at 11 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1946, to 10-28 1946 and that I last saw him alive on 10-28 1946

Immediate cause of death Massive hemorrhage into Mediastinum — Duration

Due to Aneurysm thoracic & abdominal aorta — ?

Due to Probably syphilis - 675 positive 7-22-46 & 10-25-46

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10-24-46
Major findings of operation: Abdominal aortic aneurysm
of autopsy: Aortic aneurysm - hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bruce J. Tracy M. D.
Address The Johns Hopkins Hosp Date signed 10-28-46

G45019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45019 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 Oswego Ave
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos. or days)

15-13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Oswego Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Blumberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day: hr.	min.
39				

9. Birthplace New York City (City, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Rose Blumberg
(b) Address 2717 Oswego Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)
(c) Cemetery or crematory Beth Isaac
Location North Point & Fernway Hillen Rd
18 (a) Funeral director Falk Lewis Inc
(b) Address 1739 E Balto St
19 (a) OCT 29 1946 (Date filed by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct 1946 at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Oct 1946 to Oct 25 1946, and that I last saw him living on Oct 25 1946

Immediate cause of death: (a) Acute Pulmonary Edema — Duration 1 hr
Due to (b) Coronary Thrombosis
Due to (c)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B Gross M.D.
Address 2717 Eutaw Place Date signed 10-29-46

VS 150

G15020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G15020

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1607 No Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country

3 (a) FULL NAME Yetta Kasenof

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris Hack
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs Ada Hack
(b) Address 1607 No Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1846 Park Ave

19 (a) 1946 (Date received by registrar) (Huntington Williams MD)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 21 1946, to October 27 1946, and that I last saw her alive on Oct 27 1946.

Immediate cause of death: Cardio - Respiratory failure — Duration

Due to Arteriosclerotic hypertensive cardio vascular disease

Due to Coronary occlusion & coronaridit infarction.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: None

of autopsy: Lower pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Schmidmann

Address Sinai Hospital Date signed 10/30/46 M. D.

VS 150

G15021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 43a

G15021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves.
(c) Hospital or institution: Levindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 3608 Cedardale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Coplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 82 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Lazer

13. Birthplace Russia

MOTHER 14. Maiden Name Rebecca

15. Birthplace Russia

16 (a) Informant Harry Coplan

(b) Address 3608 Cedardale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Cem

Location Joseph Levin Inc

18 (a) Funeral director

(b) Address 1869 E. Baltimore St

19 (a) 10 29 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1946 at 2:08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1946 to 10-28 1946 and that I last saw him alive on 10-28 1946.

Immediate cause of death: Cerebral hemiplegia, left — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin

Address Levindale Date signed 10/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109 B

Registered No. G45022

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 Normandy Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Normandy Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward A. Linzey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6-1884

8. AGE: Years 62 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Tobias Linzey
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Urban
15. Birthplace Balto. Co. Md.

16 (a) Informant Maude E. Linzey
(b) Address 422 Normandy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30-46 (month) (day) (year)

(c) Cemetery or crematory A. Marks. Highland Howard. Co.
Location

18 (a) Funeral director John A. Myers
(b) Address 3402 E. Balto. St

19 (a) (Date rec'd by reg.) OCT 29 1946 Williams, Md. Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1946; at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to 27 Oct 1946, and that I last saw him alive on 26 Oct 1946.

Immediate cause of death: Pneumonitis — Duration: 2 mo.

Due to: Lung abscess, right upper lobe — 6 mo.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd C. Saylor M. D.
Address 3902 Greenmount Ave Date signed 28 Oct '46

G15023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G15023 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3801 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 3801 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank L. Montague

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-18-0814-A

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Carrie W. Montague

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/26/64

8. AGE: Years 82 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Metal Worker

11. Industry or business Roofer

FATHER
12. Name Richard T. Montague
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Thomas
15. Birthplace Balto. Md.

16 (a) Informant Mrs. R. T. Montague
(b) Address 3801 Northern Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (b) Huntington Williams M.D.
Registrar

OCT 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Oct 1946, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wilson T. Kilduff M.D.
Medical Examiner.
Date signed 28 Oct 46

X

D.O.A

G15021

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30D

G15021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) V6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Newkirk St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gaitanis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	married

6 (b) Name of husband or wife George Gaitanes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1882

8. AGE: Years	Months	Days	If less than one day
64	3	4	hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Catanes
13. Birthplace Greece

MOTHER
14. Maiden Name Unknown Papa
15. Birthplace Greece

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address record

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1946 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Baltimore - Md

18 (a) Funeral director Durward D. Covington
(b) Address 21 W. 25th ST.

OCT 29 1946 (b) Date received by Registrar — Covington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1946, at 10 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1943 to 10-26 1946 and that I last saw h alive on 10-26 19 46

Immediate cause of death

	Duration
a Dissecting Aneurysm	
Due to a Coronary Thrombosis	
Due to	
Other Conditions Acute Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. Grant M.D.
Address 1101 N. Eastern Ave. Date signed 10-28-46

G15025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15025 Registered No.

CHK-105488

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20- 8- 9-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Sarah Ann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14-1926

8. AGE: Years	Months	Days	If less than one day
20	8	9	hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James Williams
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mariella Peterson
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

OCT 29 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1946, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1946 to Oct. 23 1946, and that I last saw h alive on Oct. 23 1946.

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration: 4 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Aut. Ht. with Certification

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 10-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G15026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15026 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 551 Orchard St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME Will Cochran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 30 - 18[illegible]

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	6	26		1896

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Robert Cochran

13. Birthplace

MOTHER

14. Maiden Name Sarah Jackson

15. Birthplace

16 (a) Informant Mrs Annie Queen

(b) Address 551 Orchard St. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)

(c) Cemetery Mt. Calvary Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

OCT 29 1946

17 (c) (Date received by registrar) (b) Huntington for Williamsport, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1946 at 10 [illegible] M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-25-46 to 10-25-46, and that I last saw h[illegible] alive on 10/25 1946.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 hrs
Due to Hypertension	0 yrs
Due to Arteriosclerotic Hypertensive C.V. Disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address Franklin Square Hosp. Date signed

G15027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G15027
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 N. Fine St
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N. Fine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Mc Henry / Emma May Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1901

8. AGE: Years	Months	Days	If less than one day
45	2	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, or state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John Thomas Stanty
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Virginia

16 (a) Informant John T. Stanton
(b) Address 912 - N. Fine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

OCT 29 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946 3:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1 1946 to Oct 26 1946.
and that I last saw h[illegible] alive on Oct 26 1946.

Immediate cause of death: Acute Coronary Occlusion
due to Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration: 6 Hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Greer M.D.
Address 715 N. Greene Date signed 10/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45028 97535 1/21a

Registered No. G45028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (Baltimore) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Thomas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTUS B. McQUAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mary J. McQuay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3rd. 1880

8. AGE: Years	Months	Days	If less than one day
66	9	24	hr. min.

9. Birthplace Maryland (A.A. Co.) (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James McQuay (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie E. Brown (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (ecords)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Victor Williams, M.D. Registrar

VS OCT 29 1946

MEDICAL CERTIFICATION P

20. DATE OF DEATH October 27 19 46 at 3.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 19 45 to Oct 27 19 46 and that I last saw him alive on Oct 27 19 46

Immediate cause of death Uraemia — Duration 2wk

Due to Chronic Glomerulo-Nephritis — yrs.

Due to Arteriolar Nephro-Sclerosis

Other Conditions Hypertensive Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 10/29/46

G45029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G45029 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 E. 20th St.
(c) Hospital or institution: 918

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNA E. SCHULTE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 25, 1860

8. AGE: Years	Months	Days	If less than one day
85	10	12	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Dr. Christian Schulte
13. Birthplace Germany

MOTHER
14. Maiden Name Cathrina Eliz. Howe
15. Birthplace Germany

16 (a) Informant Mr. Frank W. Schulte, Jr.
(b) Address Wash. Blvd. & Fremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar
(Name of city registrar)

OCT 29 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1946 at 12.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1946 to Oct 27 1946 and that I last saw h w alive on Oct 26 1946.

Immediate cause of death

Coronary Occlusion — Duration 1 day

Due to Arteriosclerosis — Duration Many yrs

Due to — Duration

Other Conditions Myocardial Degeneration — Duration Some yrs

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature G. F. Rau M. D.
Address 24 S. Bromley Date signed Oct 28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45030 — BALTIMORE CITY HEALTH DEPARTMENT — G45030

CERTIFICATE OF DEATH 97

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 850 W. Lombard St.
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 850 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSA BELLE JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William C. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1865

8. AGE: Years	Months	Days	If less than one day
81	8	16	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Benjamin Reynolds
13. Birthplace Va.

MOTHER
14. Maiden Name - Winfield
15. Birthplace Va.

16 (a) Informant Mrs. Susan J. Boyd
(b) Address 852 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180 OCT 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 27, 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to Uremia - Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Klumpp M. D.
Address 2607 Madison Date signed Oct 29 46

G45031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82a

G45031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 N. Howard
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 35410

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 N. Howard St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Norman Parker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Carrie Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1895

8. AGE: Years	Months	Days	If less than one day
67	-	21	hr. min.

9. Birthplace Stoney Creek, Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Emmett Parker
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Winfield
15. Birthplace Virginia

16 (a) Informant Gertrude Price
(b) Address 2505 N. Howard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) OCT 30 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1946, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/46 to 10/27/1946, and that I last saw him alive on 10/23/1946.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	1 day
Due to (b) Hypertension	10 wks
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Broadnax Higgins M. D.
Address 2743 Madison Date signed 10/27/46

VS 3

Huntington Williams

G45032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83a

G45053 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2536 Mc Culloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Mc Culloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amy S. Whiten

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Martin A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1872

8. AGE: Years	Months	Days	If less than one day
74	5	6	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Minerva Squirrell
15. Birthplace Maryland

16 (a) Informant Martha A. Whiten
(b) Address 2536 Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Sara A. Whitaker
(b) Address 1628 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1946 at 8:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 15 1946 to Oct 25 1946, and that I last saw h[illegible] alive on Oct 25 1946

Immediate cause of death

(a) Cerebral Hemorrhage
(b) Hypertension
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 11 Months

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2536 Mc Culloh St Date signed Oct 28 1946

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45033 ~~G45033~~ G45033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √121a

Registered G45033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Frederick Ave
(c) Hospital or institution: St Joseph Monastery
(d) Length of stay in hospital or inst. (yrs., mos., or days) √
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Frederick Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Father Mark (Andrew Moeslein)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1854

8. AGE: Years 92 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Bavaria (Town, county, and state)

10. Usual Occupation R.C. Priest

11. Industry or business

FATHER 12. Name Caspar Moeslein
13. Birthplace Not Known

MOTHER 14. Maiden Name Magdalena Fuchsner
15. Birthplace Not Known

16 (a) Informant Monastery Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-46 (Month) (day) (year)
(c) Cemetery or crematory Loretto Cemetery
Location Catonsville Md

18 (a) Funeral director Sisters of Poverty
(b) Address Catonsville Md

19 (a) (Date received) (b) Registrar

OCT 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1946 at 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Oct 28 1946 and that I last saw h alive on Oct 27 1946

Immediate cause of death: Arteriosclerotic Cardiac

Due to Uraemia Nephritis

Due to

Other Conditions Senescence & Pemphigus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.W. Collins M.D.

Address 332 Frederick Ave Date signed 10-28-46

X

G45034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45034

Registered No. 830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 344 E. Lombard St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Childs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva Marie Childs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1885

8. AGE: Years	Months	Days	If less than one day
61	1	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Conductor - Pull-Transit

11. Industry or business Baltimore Transit

FATHER
12. Name Charles Childs
13. Birthplace Maryland

MOTHER
14. Maiden Name Sallie Woodson
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director Lilly + Leith
(b) Address 4038 Wolfe St.

19 OCT 29 1946 (Date filed by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1946, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1946 to Oct 27 1946 and that I last saw him alive on Oct 27 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cerebral Vascular Accident (Hemorrhage)	
Due to Hypertension (?)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams Jr. M.D.
Address Mercy Hospital Date signed 10-31-46

VS 150

The G45035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

Registered No. 36798 G45035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 Mount St.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 N. Mount St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Crews
3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Calvin Crews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-81

8. AGE: Years 65 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Charles Co. Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Own home

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Anne Mitchell
15. Birthplace Charles Co. Md

16 (a) Informant Calvin Crews
(b) Address 1328 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month, day, year)
(c) Cemetery or crematory St. Peters
Location W. D. Kelso

18 (a) Funeral director Geo. D. Kelso
(b) Address 1303 Pressman St

OCT 29 1946 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1946, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1946, to 10-26- 1946, and that I last saw her alive on 10-25 1946.

Immediate cause of death: Myocarditis — Duration: unknown

Due to

Due to

Other Conditions: Hypertension and arteriosclerosis — unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 10-29-46

VS 150

G45036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45036 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Harewood Park (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 14 Box 208 F (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward JAMES PEYTON.

3 (b) If veteran, name war

6 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Lama Peyton nee Carbuck
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Aug. 28-1919

8. AGE: Years	Months	Days	If less than one day
27	1	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Balto Co. Highway Dept.

FATHER
12. Name Luther Peyton
13. Birthplace Va.

MOTHER
14. Maiden Name Marie Stansbury
15. Birthplace Va.

16 (a) Informant Leonard Carbuck
(b) Address Route 14 Box 208

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29-46 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Chase, Md.

18 (a) Funeral director John G. Connolly
(b) Address 418 Eastern Ave. Essex

19 (a) (Date received by district registrar) (b) Registrar

Oct 29 1946 Huntington Hill

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1946, at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1946, to Oct 24 1946, and that I last saw h alive on Oct 24 1946.

Immediate cause of death Emaciation.

Duration

Due to Cancer Unknown

Due to

Other Conditions Cirrh. pancreatitis (Acute?)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cavity malignancy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Rother M. D.
Address Sinai Hosp Date signed Oct 29 1946

Rother X

G45037 Nicholas Milinsky

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G45037 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 N Broadway St
(c) Hospital or institution: St Joseph Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13d.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Cambridge St.
(If rural give location)
(e) Citizen of foreign country? Russia (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Nicholas Milinsky.

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-07-5538

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married.

6 (b) Name of husband or wife Helen.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 Dec, 1893

8. AGE: Years	Months	Days	If less than one day
52	10	9	hr. min.

9. Birthplace MINSK, RUSSIA (Town, county, and state)
10. Usual Occupation Carpenter.
11. Industry or business Sparrows Point Shipyard

FATHER
12. Name Gregory Malinsky
13. Birthplace Minsk, Russia

MOTHER
14. Maiden Name Justina (Unknown)
15. Birthplace Minsk, Russia

16 (a) Informant Johanna M. Malinsky (wife)
(b) Address 2240 Cambridge St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Andrews Russian
Location Levittown, Pa.

18 (a) Funeral director Walter Brooke Bradley
(b) Address 1922 W. North Ave.

19 (a) Date received by Local Registrar OCT 29 1946
(b) Registration No. 1946 Huntington Hillcrest, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 | 27 1946, at 12:38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1946 to 10/27 1946 and that I last saw him alive on 10/27 1946.

Immediate cause of death: Congestion Heart failure.
Due to Coronary artery occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard N. Young M.D.
Address St. Joseph Hosp. Date signed 10/29/46

X

G15038 P.G. 60665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G15038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKING ALTERATIONS FOR ERASING RESERVED

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave.
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2555 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Clarke
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 26, 1946
8. AGE: Years Months Days 3 2 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Clarke
13. Birthplace Plattsburg N.Y.

MOTHER
14. Maiden Name Olive Anthony
15. Birthplace Manor, Pa.

16 (a) Informant Edward A. Clarke
(b) Address 2555 W. Lafayette Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30, 1946 (month) (day) (year)
(c) Cemetery or crematory Rural Creek
Location Manor, Pennsylvania
18 (a) Funeral director Walter Rowe Brantley
(b) Address 822 W. North Avenue
19 (a) OCT 29 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1946 at 6:10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1946 to 10-28 1946 and that I last saw her alive on 10-28 1946.

Immediate cause of death Congenital Heart Disease — Duration
Due to
Due to
Other Conditions Intra-Cranial Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Congenital Ht Ds

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. J. Treptow M. D.
Address W. Balto. Genthorp Date signed 10-29-46

VS 150

Huntington Williams, M.D.

G45039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G45039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1. Highland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 1 N. Highland Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mina Clyde Mowbray

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Geo H. Mowbray
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Oct 31. 1871

8. AGE: Years	Months	Days	If less than one day
74	11	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Wm Todd
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth James
15. Birthplace Md

16 (a) Informant Otley Mowbray
(b) Address 1 N Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) OCT 29 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946 at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Oct 26 1946 and that I last saw h alive on Oct 26 1946.

Immediate cause of death Myocardial Insufficiency
Due to Arterio Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 10 days

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature J. V. Clift
Address 5010 Greenleaf Road Date signed 10 28 46

VS 180

G45010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G45010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robena Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Divorced

6 (b) Name of husband or wife John Patterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-2-1897

8. AGE: Years	Months	Days	If less than one day
48	10	23	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name Washington Henderson.
13. Birthplace Miss.

MOTHER
14. Maiden Name Penny Perry
15. Birthplace Va.

16 (a) Informant Reenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (Date rec'd by registrar) OCT 29 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1946, at 9.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946, to Oct. 25 1946, and that I last saw h. alive on Oct. 25 1946.

Immediate cause of death	Duration
Cerebral hemorrhage c	
subarachnoid extension	
Due to Hypertensive C V disease	18 hrs, Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. J. Davis
Address Johns Hopkins Hospital Date signed 10/29/46 M. D.

VS 150

G15011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G15011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address President Hosp.
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give name of county)
(d) Street No. 1007 Somerset St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mable Lee Person

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife James C. Person
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1899

8. AGE: Years	Months	Days	If less than one day
47	8	20	hr. min.

9. Birthplace Midland Va. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Calvin Jackson
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Taylor
15. Birthplace Va.

16 (a) Informant Geneva Hodges
(b) Address 531 Clifton Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Oct 31 1946 (month) (day) (yr.)
(c) Cemetery or crematory Midland Va.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 OCT 29 1946 (Date rec'd by local registrar) Katie Williams, Mgr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1946 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/46 to 19 ; and that I last saw h alive on 10/27/46

Immediate cause of death Duration

Due to Cerebral Hemorrhage Hours

Due to Hypertensive Heart Disease Years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Holcomb M. D.
Address 431 Harlem Date signed 10/29/46

X

G15012 BC# B09126 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH V13 B Registered No. G15012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 N. Mount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) Country U
(c) City or town Balto.
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 209 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Turner Jas.
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1944

8. AGE: Years	Months	Days	If less than one day
2	1	8	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER	12. Name Frederick Turner
	13. Birthplace Balto. Md.
MOTHER	14. Maiden Name Etta Green
	15. Birthplace Balto. Md.

16 (a) Informant Etta Turner
(b) Address 209 N. Mount St.
17 (a) Burial (b) Date thereof Oct. 29/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory W. H. Lubeary Cem.
Location
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St
19 (a) OCT 29 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1946, at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1946 to Oct 27 1946, and that I last saw h[illegible] alive on Oct 27 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Reckling, M.D.
Address 4 E. N. Ave Date signed 10-29-46

R. W. Reckling X

G45013 — BALTIMORE CITY HEALTH DEPARTMENT — G45013

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Hilton Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 N. Glover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CATHERINE KRUEGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Frank Krueger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1883

8. AGE: Years	Months	Days	If less than one day
63 yrs.	1	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

PARENTS
12. Name unknown DOEMLING.
13. Birthplace W

MOTHER
14. Maiden Name W
15. Birthplace W

16 (a) Informant August Krueger
(b) Address 214 N. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Signature of registrar) (b) Registrar

OCT 29 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946 at 5 30p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1946 to Oct 26 1946 and that I last saw h[illegible] alive on Oct 26 1946

Immediate cause of death	Duration
Empyema Pneumonia	12 hr
Empyema Lung	12 hr
Due to Myocarditis (Senile)	3 d.
Heart Decompensation	2 d.
Due to Gen. Arteriosclerosis Kidneys	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 2618 Harford Av Date signed 10/28/46 M

G45011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √46E

G45011 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp 61
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7. N. Stricker (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Walters

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife Leonard G.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Apr 11 1883

8. AGE: Years	Months	Days	If less than one day
63	6	9	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation H W
11. Industry or business

FATHER
12. Name Wm Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Seibert
15. Birthplace Balto Md

16 (a) Informant John Walters
(b) Address 7 N. Stricker

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 46 (Month) (Day) (Year)
(c) Cemetery or crematory Loudon Park
Location Caton Ave

18 (a) Funeral director J. C. Upshur
(b) Address 2818 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

OCT 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1946 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1946 to 10-26 1946, and that I last saw h.. alive on 10-26 1946.

Immediate cause of death Carcinomatosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10-22-46
Major findings of operation: Carcinoma of Uterus Ovaries
of autopsy: Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Harley M. D.
Address Univ Hosp Date signed 10-26-46

X

G45015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45015 Registered No. 1218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 E. Madison
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Sophia E. Bauer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John B. Bauer
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1857

8. AGE: Years 88 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Henry Zaechalein
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Volkhart
15. Birthplace Germany

16 (a) Informant Mr. Geo. Bauer
(b) Address 2928 E. Madison St Balto Md

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct. 30, 46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Linden Lane

18 (a) Funeral director L. Heemann Son
(b) Address 32 S. Broadway

19 (a) OCT 29 1946 (Date rec'd by registrar) Registrar Huntington Williamsa, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27, 1946, 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27, 1945 to Oct 27, 1946
that I last saw her alive on Oct 25, 1946

Immediate cause of death Cardio-Vascular disease | Duration 5 years 1 yr
Due to Arteriosclerosis
Due to senility
Other Conditions Intermittent

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Fritz J Kimzey M.D.
Address 2700 Harford Rd Date signed 10/30/46

X

G45016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45016 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Grafton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Thayer Street.
Local: 717 - W.Lombard St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME "" William Werner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name W. Werner
13. Birthplace West Virginia

MOTHER
14. Maiden Name Lena Campbell
15. Birthplace West Virginia

16 (a) Informant Bartlett Funeral Home
(b) Address Grafton, West Virginia

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 29 '46 (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetary
Location Grafton, West Virginia

18 (a) Funeral director Wm. J. Tichnell & Sons
(b) Address W. V. & Penna. Lines (17)

19 (a) Date received Oct 29 1946 (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1946, at 11.30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumococcic pericarditis
Pneumococcic empyema
Lobar pneumonia, rt.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/29/46

G45017 BC# B 58544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133 B

G45017 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd st
(c) Hospital or institution: Union Memorial Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore - 16
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Poplar Grove st.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Edward Grempler, III

3 (b) If veteran, name war	3 (c) Social Security Account No.
0	0

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3rd 1946

8. AGE: Years	Months	Days	If less than one day
		26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation 0
11. Industry or business 0

FATHER
12. Name Walter E. Grempler Jr.
13. Birthplace Balto.

MOTHER
14. Maiden Name Lyllian E. Lent
15. Birthplace Balto.

16 (a) Informant Father
(b) Address above.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

OCT 29 1946

VS 400

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946 at 7 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946 to Oct 29 1946 and that I last saw him alive on Oct 25 1946

Immediate cause of death	Duration
Renal insufficiency	
Due to Urinary Obstruction	7 Da.
Due to Hydronephrosis and Hydroureter bilateral	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy Urinary Obstruction.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ronald D. Cooper M. D.
Address Union Memorial Hosp. Date signed 29 Oct 1946

G15018
397461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52 B

G15018
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford County
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Bloomsbury Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Iverson Frank Triplett

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 214-18-2808

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Hattie Triplett
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 6-9-86

8. AGE: Years	Months	Days	If less than one day
60	4	20	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business

FATHER
12. Name Perry Triplett
13. Birthplace Georgia

MOTHER
14. Maiden Name Mary ? ? ? ?
15. Birthplace Illinois

16 (a) Informant JOHNS HOPKINS HOSPITAL records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace, Md.
18 (a) Funeral director H. Magnus Mitchell
(b) Address Havre de Grace, Md.
19 (a) [illegible] Huntington Williams M.D.
(b) Date received by Local Registrar OCT 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1946, to 10-29 1946, and that I last saw h[illegible] alive on 10-29 1946.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Post operative exploratory for Carcinoma of Bladder	6 days
Due to	
Other Conditions Nephrosclerosis Hypertensive Heart Disease	

(Include pregnancy within past month of death)

Date of operation 10-25-46
Major findings of operation: Carcinoma of Bladder
of autopsy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard E. Goodwin
Address Johns Hopkins Hospital Date signed 10-30-46

WILLARD E. GOODWIN

G45019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G45019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 W. Mount Royal Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. Mount Royal Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER P. PENTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora G. Pentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1886

8. AGE: Years	Months	Days	If less than one day
59	10	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Night Auditor
11. Industry or business Arundel Hotel

FATHER 12. Name Thomas Pentz
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Katie (Watkinson)
15. Birthplace Holy Corners

16 (a) Informant Donald Pentz
(b) Address 11 W. Mount Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Colegate
(b) Address 1214 E Fayette St

19 OCT 30 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946 at 1:08 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/29/46

G45050 BALTIMORE CITY HEALTH DEPARTMENT G45050
CERTIFICATE OF DEATH 1318 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Brent St
(c) Hospital or institution: —
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Brent St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes W Gladden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lillian Gray Grace
(b) Address 1619 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 10-30-46
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1613 N Carey St

19 (a) Filed (b) OCT 30 1946 Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/46 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2/46 to 10/24/46.
and that I last saw h[illegible] alive on 10/25/1946.

Immediate cause of death Chr. Nephritis
Due to Uremia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burk Coltt M. D.
Address 1717 Brent St Date signed 10/28/46

G45051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G45051 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2933 Belmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE V. SLATTERY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Herman J. Slattery
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19-1913

8. AGE: Years	Months	Days	If less than one day
32	10	8	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Office worker at American
11. Industry or business Hammer Piston Ring

FATHER
12. Name Joseph W. Bennanzer
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Carrie Cox
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Carrie Bennanzer
(b) Address 2933 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31, 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Ellsworth Burneston
(b) Address 3911 Liberty Heights Ave.

19 (a) Oct 30 1946 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1946, at 3.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/28/46

G45052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G45052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 N. Ellwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward A Stinchcomb

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-9691

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Elizabeth Stinchcomb

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 20 - 1890

8. AGE: Years 56 | Months - | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Annapolis Md (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Garage Clerk

FATHER
12. Name Ashby Stinchcomb
13. Birthplace Annapolis Md

MOTHER
14. Maiden Name Sarah Spriggs
15. Birthplace Annapolis Md

16 (a) Informant Elizabeth Stinchcomb
(b) Address 433 N Ellwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Chas P Powell
(b) Address 3027 Edmondson Ave

19 (a) OCT 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1946 at 3.13 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Grace G. Merrill M.D. Medical Examiner.
Date signed 10/29/46

VS 191

G15053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193c

G15053
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3611 Grantley Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Grantley Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah L. Halpern

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Joseph | 6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Moses
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Willyne Mathyan
(b) Address 3611 Grantley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Levey Inc
(b) Address 1429 E Balto St

19 (a) Date received by Local Registrar OCT 30 1946 Huntington Williams, Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1946 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1946 to 10/29 1946 and that I last saw L alive on 10/29 1946.

Immediate cause of death
CORONARY THROMBOSIS — Duration 2 DAYS

Due to ART. SCLEROT. CARDIOVAS. DIS. — Duration ?

Due to — Duration

Other Conditions ARTHRITIS — Duration ?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M. D.
Address 1206 E. Pratt St Date signed 10 31 46

X

G45054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G45054
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Chalgrove Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Chalgrove Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Katz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Ruben
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Charles Katz
(b) Address 1104 Chalgrove Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-46 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run
18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St
19 (a) (Date rec'd by registrar) (b) Registrar

VS/80T OCT 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1946 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 5 1946 to Oct 29 1946, and that I last saw h alive on Oct 28 1946.

Immediate cause of death: CORONARY THROMBOSIS. — Duration: SUDDEN

Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to

Other Conditions DIABETES MELLITUS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum, M.D.
Address 1066 E. Fayette St Date signed 10/29/46

93D

G45055 — BALTIMORE CITY HEALTH DEPARTMENT — G45055

CERTIFICATE OF DEATH 52a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 9W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 N. Carolina St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Austria

3 (a) **FULL NAME** Myron D. Boyko (Myron D. Boyko)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Florence A. Boyko
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4 1885

8. AGE: Years	Months	Days	If less than one day
60	11	23	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Louis Boyko,
13. Birthplace Poland

MOTHER
14. Maiden Name Hannah Sobel,
15. Birthplace Poland

16 (a) Informant Mr. Edgar P. Boyko,
(b) Address 1510 N. Bayview St.

17 (a) Cremation (b) Date thereof 10/30/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Baird Jacobsen & Long
(b) Address 902 Eutaw Place

19 (a) (b) Registrar
(Date received)

OCT 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1946, at 7^00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1946, to 10-27 1946, and that I last saw him alive on 10-27 1946.

Immediate cause of death: Hypernephroma — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: HYPERNEPHROMA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harland S. Hyman, M. D.
Address Sinai Hospital Date signed 10-29-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45056 104772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G45056

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-Month & 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city give name of township RURAL and give town) Greenspring
(d) Street No. 5922 ~~Greenmount~~ Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kronenberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23rd. 1907

8. AGE: Years	Months	Days	If less than one day
39	0	4	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Kroenberger
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Pfisterer
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Chenoweth & Donovan
(b) Address 2615-17 Chestnut Ave

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 30 1946 Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27th 1946 at 8:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 25/ 1946 to Oct 27 1946 and that I last saw him alive on Oct 27/ 1946

Immediate cause of death: Liver Failure — Duration 3 mo.

Due to Jaundice Cirrhosis — yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cirrhosis of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 10/28/46

VS 150 (OCR)

G45057 BC# D54804 — BALTIMORE CITY HEALTH DEPARTMENT — G45057 Registered No.

CERTIFICATE OF DEATH 182a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - Windsor Ct. apt. (If outside city or town limits, write RURAL and give town)
(d) Street No. Garrison blvd. & Windsor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Weidman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26/1946

8. AGE: Years	Months	Days	If less than one day
	2	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Walter Weidman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Gloria Elizabeth Godwin
15. Birthplace Baltimore Md

16 (a) Informant Edward Walter Weidman
(b) Address Windsor Court Apts J 3

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Harry A Armacost
(b) Address 4204 Ridgewood Ave

19 (a) OCT 30 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1946, at 10 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Bad clothing
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-26- at 15/8 a. M.
(b) Where did injury occur? Above railroad
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Bad clothing

23. Signature Howard J. MacClain M.D. Medical Examiner.
Date signed 10-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15058 — BALTIMORE CITY HEALTH DEPARTMENT — G15058

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4306 Norwood road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4306 Norwood road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE E. HETZ

3 (b) If veteran, name war: -----

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 9 - 1885

8. AGE: Years	Months	Days	If less than one day
61	6	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Robert Hetz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jennie Sendelbach
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Bertha Sendelbach
(b) Address 4306 Norwood road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 116 W. Mt. Royal Ave.

19 (a) (Date received by Registrar) OCT 30 1946 Hunting Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946 to 19 , and that I last saw h alive on Oct 28 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Hypertension	Several yr.
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature O. F. Rice, M.D.
Address 24 S. Bway Date signed 10/29/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 R

✓ G15059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1043 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Langley

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-8036

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/91

8. AGE: Years	Months	Days	If less than one day
55	4	22	hr. min.

9. Birthplace Va. (Town, county and state)
10. Usual Occupation Oyster Shucker
11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name Violett Lockett
15. Birthplace Va.

16 (a) Informant Rebecca Langley
(b) Address 1043 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Lockett
(b) Address 1304 N. Central Ave

19 (a) OCT 30 1946 (Date received by registrar) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1946 at 9 57 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/1 1946 to 10/28 1946 and that I last saw him alive on 10/28 1946.

Immediate cause of death: Heart-Disease (Decompensated) — Duration: 4 hrs.
Due to Nephritis — Duration: 4 hrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Central Ave

VS 150

X

G45060 ✓ G45060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Holman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife Margaret Holley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1871

8. AGE: Years 75 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Labourer

11. Industry or business

FATHER
12. Name Morder Holoman
13. Birthplace Russia

MOTHER
14. Maiden Name Catherina Schulstan
15. Birthplace Russia

16 (a) Informant Sister Superior
(b) Address 1200 Valley St Baltimore City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A A. Co.

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Baltimore St Huntington Williams, Md

19 (a) (Date received by registrar) (b) Registrar

OCT 30 1946
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1946, at 12:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1946, to Oct 28 1946, and that I last saw him alive on Oct 25 1946.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Bronchial Asthma	a yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1021 E North Ave Date signed 10/29/46

G15061 ✓ G15061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dakeland + Rayner Ave.

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4206 Pall Mall Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME SADIE BECKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Late Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER 12. Name

13. Birthplace Poland

MOTHER 14. Maiden Name Adele Gabell

15. Birthplace Poland

16 (a) Informant Benjamin Becker

(b) Address 1202 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/46 (month) (day) (year)

(c) Cemetery or crematory New York N.Y.

Location

18 (a) Funeral director Sol Leipsner & Bros

(b) Address 1124-26 W. North ave

19 (a) (b) Date received Registrar Huntington Williams M.D.

OCT 30 1946

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30, 1946 at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1946 to Oct 30 1946 and that I last saw h&R alive on Oct 29, 1946.

Immediate cause of death	Duration
PERIPHERAL CIRCULATORY COLLAPSE	
Due to CEREBRAL EDEMA	
Due to HYPERTENSIVE CARDIO VASCULAR DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Gabrielsky M. D.

Address 3706 Rosedale Rd Date signed 10/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC# G59343 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. G15062

G15062 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Johnstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 670 Cypress Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Krone

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1946

8. AGE: Years	Months	Days	If less than one day
—	—	20	— hr. — min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Krone
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Martha Bomba
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Margaret Krone
(b) Address 670 Cypress Ave., Johnstown, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-46 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto Md.

18 (a) Funeral director George D. Farley
(b) Address Fayette & Fulton Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946, at 2:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 19 46 to Oct 22, 1946, and that I last saw h[illegible] alive on Oct 22 19 46

Immediate cause of death	Duration
Cardio-resp. failure	
Due to Neo natal Gonorrhea (Adenopathies)	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas R. Connor M.D.
Address Mercy Hospital Date signed 10/24/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 S. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 S. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis F. Smallwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Agnes Slaughter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1897

8. AGE: Years	Months	Days	If less than one day
49	3	9	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business Gen'l Chemical Co.

FATHER
12. Name John Smallwood
13. Birthplace West Virginia

MOTHER
14. Maiden Name Jeane Flemings
15. Birthplace West Virginia

16 (a) Informant Mrs. Agnes Smallwood
(b) Address 210 S. Fulton Ave.

17 (a) Burial (b) Date thereof 11/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) [illegible] Thurston Williams, Registrar
OCT 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1946, to Oct 28 1946, and that I last saw him alive on Oct 28 1946

Immediate cause of death	Duration
Left pyo pneumothorax	2½ months
Due to Bronchio pleural fistula, left lower	3 months
Due to Pulmonary tuberculosis	unknown
Other Conditions Bronchiectasis, Left	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen
Address 206 S. Gilmor St Date signed 10. 29. 46

G15061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G15061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Mc Kean ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Keiner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	widow

6 (b) Name of husband or wife Late John Keiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
75 74			hr. min.

9. Birthplace Md
10. Usual Occupation H.W. (Town, county, and state)
11. Industry or business

FATHER
12. Name Burkhart
13. Birthplace Md

MOTHER
14. Maiden Name Favel
15. Birthplace Md

16 (a) Informant Geo. W. Clazey
(b) Address 1613 McKean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Nikle
(b) Address 4101 Edmondson ave

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/ 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1946, to Oct 27 1946, and that I last saw her alive on Oct 27 1946.

Immediate cause of death Cardio respiratory failure — Duration

Due to Arteriosclerotic Heart Disease

Due to Hypertension, right hemiplegia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Not Asked

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address Sinai Hospital Date signed 10/30/46 M. D.

X

G45065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G45065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Home~~
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3035 Westfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Vinje

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Oscar R. Vinje
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) November 27, 1876

8. AGE: Years	Months	Days	If less than one day
69	11	2	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Elias Peters
13. Birthplace Norway

MOTHER
14. Maiden Name Antonnette —
15. Birthplace Norway

16 (a) Informant Oscar R. Vinje
(b) Address 3035 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Alexandria Va.

18 (a) Funeral director Howard W. Blight & Son
(b) Address 4914 Belair Road.

19 (a) (Date signed by attendant) (b) Huntington Williamsburg M.D.

OCT 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1946, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1946 to 10-29 1946, and that I last saw h alive on 10-29 1946.

Immediate cause of death Cardiac failure

Due to coronary occlusion

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. O. Starly M. D.
Address Univ. Hosp. Date signed 10-29-46

G45066
Th.

105016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12B

Reg. G45066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S. Lehigh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Bock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5th 1909

8. AGE:	Years	Months	Days	If less than one day
	37	6	22	hr. min.

9. Birthplace Wisconsin
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Bock
13. Birthplace Istonia

MOTHER
14. Maiden Name Marie
15. Birthplace Istonia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 1946 (Month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Edmondson Ave
18 (a) Funeral director Randall Hagood
(b) Address 3123 Hoffman St

19 (a) OCT 30 1946 Interment, Removal, or Cremation

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct /27/ 1946 19 . at 1.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct/4th 19 46 to Oct 27 1946.
and that I last saw him alive on Oct 27 19 46

Immediate cause of death
Pulmonary Tuberculosis, Far Advanced — Duration 1yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 10-28-46

G45067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G45067 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Hollins Ferry Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Hollins Ferry Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Dorothea Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife John Louis Kelly
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October-5-1880

8. AGE: Years	Months	Days	If less than one day
66	0	24	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Julius Astfalk
13. Birthplace Germany

MOTHER
14. Maiden Name Emilie Knabe
15. Birthplace Germany Sonnenleite

16 (a) Informant Dorothea Sonnenleiter
(b) Address 2914 Hollins Ferry Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem
Location Wash Blvd

18 (a) Funeral director Edward Tonkyn
(b) Address 2907 Wash Blvd.

19 (a) Huntington Williams, M.D. Registrar

OCT 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October-29-1946 at 1405 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to October 1946, and that I last saw h alive on October-29-46.

Immediate cause of death Carcinoma — metastasis in both lungs — Duration

Due to Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeldt
Address 2706 Hollins Ferry Rd Date signed 10/29/46

X

G45068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G45068
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. High St. (If not numbered give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde J. May

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1[illegible]

8. AGE: Years 39 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business C.J. Lavy Co.

MOTHER FATHER
12. Name George V. May
13. Birthplace Va.
14. Maiden Name Mary Hinton
15. Birthplace Va.

16 (a) Informant George V.May
(b) Address 23 N. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext'd

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 Wolfe St.

19 (a) OCT 30 1946 (Must be filed within 5 days) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1946 at 4.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury found 10-26-46- 4 P. M.
(b) Where did injury occur? "ewgate Ave. #3" elevat[illegible]
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found- drowned.

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/28/46

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45069

AB-102961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G45069

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos- 12days
(e) Length of stay in Baltimore (yrs., mos., or days) 19yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Herbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Cramer-

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16- 1901

8. AGE: Years	Months	Days	If less than one day
45	0	13	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business

FATHER
12. Name Charles Cramer (D
13. Birthplace Pa.

MOTHER
14. Maiden Name Alice Armstrong (D
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2939 Frederick Ave Baltimore Md

18 (a) Funeral director Oehler & Conrad Inc
(b) Address 20-03 Eutaw St

19 (a) Date received OCT 30 1946 (b) Registrar's signature for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29- 1946, at 12.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1946 to 10-29 1946 and that I last saw h alive on 10-29- 1946

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions For advanced carcinoma of cervix with metastasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R F Sibbs M. D.
Address Baltimore City Hosp. Date signed 10/29/46

G45070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G45070 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil Co. Md
(c) City or town ~~Baltimore~~ Cecil Co - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~541 W. Washington St.~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph G. Harrington

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Vedar E. Boyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 21 1867

8. AGE: Years 79 | Months 8 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name William Harrington
13. Birthplace Va

MOTHER 14. Maiden Name Matilda Hall
15. Birthplace Va

16 (a) Informant Forrest H. Kehne
(b) Address 729 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2-46 (month) (day) (year)
(c) Cemetery or crematory West Nottingham Cem
Location Cecil Co. Md

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date filed by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1946 at 7.30 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Arteriosclerotic heart disease
Due to Fracture of the 3rd cervical vertebrae
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/24/46 at 345 P. M. 26/1 M.
(b) Where did injury occur? Belair Rd at White Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Auto collision over

23. Signature George S. Merrill M.D.
Medical Examiner.
Date signed 10/30/46

G45071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G35071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 E. Fort Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Kelly

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/12/1870

8. AGE: Years	Months	Days	If less than one day
76	6	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Unk
13. Birthplace

MOTHER
14. Maiden Name Unk.
15. Birthplace

16 (a) Informant Family
(b) Address 503 E. Fort Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

OCT 30 1946
Date received by Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/46 2:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20/1946 to 10/25/1946
and that I last saw h alive on 19

Immediate cause of death

	Duration
Coronary thrombosis	1 hour
Due to arteriosclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Isaac Muller M. D.
Address 1225 Eutaw Date signed

10/29/46

G45072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 B

Registered No. G45072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Dunagan "(Dungan)"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/1899

8. AGE: Years	Months	Days	If less than one day
47	3	29th	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kepper
13. Birthplace Md.

MOTHER
14. Maiden Name Christina ?
15. Birthplace Md.

16 (a) Informant Family
(b) Address 131 E. Fort Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director J. F. McCauley
(b) Address 130 E. Fort Ave.

19 (a) OCT 30 1946 (Date rec'd by registrar) (b) Huntington Hill Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1946 at 9.55 A.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 10/29/46

correct age is especially important. Physicians: please write the

G15073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G15073 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 E 22nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 E 22nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Walker Taylor

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: one
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Ella C Taylor
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 30 1861
8. AGE: Years 85 | Months 2 | Days 29 | If less than one day: hr. min.
9. Birthplace: Baltimore Co Md (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: George Taylor
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Harriett Walker
15. Birthplace: Pa

16 (a) Informant: Emmett E Klemm
(b) Address: 193 E 22nd St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/1/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md
18 (a) Funeral director: Fallon & Son
(b) Address: 1214 E Fort Ave
OCT 30 1946
(Date rec'd by registrar) (b) Emmett Williams Klemm

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1946 at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938, to Oct. 29 1946, and that I last saw h.i.t.h. alive on Oct. 26 1946.

Immediate cause of death: Coronary thrombosis
Due to: Cerebral thrombosis.
Due to: Arteriosclerosis and hypertension
Due to:
Other Conditions: General senile changes.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
Sudden.
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur abou: home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Robt. H. Wright M. D.
Address: Macies Arts. Date signed: 10/30/46

VS 150

G45074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45074 Registered No. 302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Duffin (Duffy)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/1897

8. AGE: Years	Months	Days	If less than one day
49	3	15	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Penna R.R.

11. Industry or business

FATHER
12. Name Chas Duffin
13. Birthplace md

MOTHER
14. Maiden Name Jeanette —
15. Birthplace md

16 (a) Informant Mary Duffin
(b) Address 1815 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. E. Kelson
(b) Address 1803 Pennsylvania Ave

19 (a) 10-30-1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1946 at 12.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 10/29/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G45075

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Wheatcroft St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Thomas.

3 (b) If veteran, name war	3 (c) Social Security Account No.
Unknown	unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Black	M

6 (b) Name of husband or wife Beatrice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-09.

8. AGE: Years	Months	Days	If less than one day
37	4	17	hr. min.

9. Birthplace VA (town, county and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Wesley Thomas
13. Birthplace Va

MOTHER
14. Maiden Name Rosa ?
15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Reisterstown.

17 (a) Burial (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory Gulntees
Location Md

18 (a) Funeral director Geo. M. Kelson
(b) Address 1303 Pennsylvania Ave

19 NOV 30 1946 (b) Huntington Maryland

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 29 1946, at 2. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1946 to Oct. 29 1946, and that I last saw him alive on Oct. 29 1946,

Immediate cause of death UREMIA AND CARDIAC FAILURE — Duration 1 MONTH

Due to CHRONIC GLOMERULO NEPHRITIS ?

Due to

Other Conditions SEVERE ANEMIA HYPERTENSION (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ABOVE

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Brennan S Stephens M. D.
Address Johns Hopkins Hospital Date signed 10-29-46

VS 150

G45076 G45076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Chestnut Hill ave.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Chestnut Hill ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE A. KING

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert King, Sr.

6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1885

8. AGE: Years	Months	Days	If less than one day
61	1	4	hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael F. Giles
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Carolona P. Ludwig
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Robert W. King, Sr.
(b) Address: 515 Chestnut Hill avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cemetery
Location

18 (a) Funeral director: Chas. E. Evans & Son
(b) Address: 118 W. Mt. Royal Ave.

19 (a) ____ (b) ____
(Date received by registrar) (Registrar)
OCT 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946 at 9:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from May 21 '42 to Oct 28 1946, and that I last saw h[illegible] alive on Oct 25 1946.

Immediate cause of death: Cerebral hemorrhage — Duration: 3 days

Due to: Arteriosclerosis — ? ?

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Samuel H. Gilson M. D.
Address 96 W. Pendleton St. Date signed

X

G15077 BCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

F 28995 ✓ 178X

G15077
Registered No.

Please answer the questions on the causes of death clearly and legibly. Physicians: please write the information as is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8112 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Diffendall Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1941

8. AGE: Years	Months	Days	If less than one day
✓	5	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Charles A. Diffendall
13. Birthplace Maryland.

MOTHER
14. Maiden Name Isabell Brewer
15. Birthplace Baltimore Md.

16 (a) Informant Charles A. Diffendall Jr.
(b) Address 8112 Eastern Ave

17 (a) Entombment (b) Date thereof 10/31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Rd

18 (a) Funeral director John F Denny Dec
(b) Address 714 Light St.

19 (a) 30 Oct 1946 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 October 1946, at 11:50 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-26-46 at 11 p. M.
(b) Where did injury occur? 8112 Eastern Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? No
(d) Means of injury inhaled gasoline fumes

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 27 Oct 1946

VS 181

History # 32 2106

G45078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45078 Registered No. 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Brooklyn, N.Y. (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 E. 54th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Barry Roy Gelwick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-42

8. AGE: Years	Months	Days	If less than one day
3	10	18	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Herman Gelwick
13. Birthplace New York

MOTHER
14. Maiden Name Yetta Polan
15. Birthplace New York

16 (a) Informant records
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/46 (month) (day) (year)
(c) Cemetery or crematory New Montefiore
Location Brooklyn New York
18 (a) Funeral director Sol Zeramit Bros
(b) Address 1124-26th Huntington Williams, Md.
19 Oct 30 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1946 at 2 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1946 to Oct 30 1946, and that I last saw h alive on Oct 30 1946.
Immediate cause of death Cardiac arrest — Duration
Due to Operation
Due to Tetralogy of Fallot — Life
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Oct 30 1946
Major findings of operation: Small pulm. artery
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry T. Bahnson
Address Johns Hopkins Hosp. Date signed 10/30/46 M. D.

VS 150

G15079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15079 Registered No.

1170C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: FRANKLIN SQUARE HOSPITAL 20
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTO. 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. BENTALOU ST. (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) **FULL NAME** FRANCIS J. KUHL

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret W. Kuhl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 27 1865

8. AGE: Years 80 | Months 11 | Days 2 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (town, county, and state)
10. Usual Occupation: Shoe Welder
11. Industry or business: Retired

FATHER
12. Name: Frederick Kuhl
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Schilling
15. Birthplace: Pennsylvania

16 (a) Informant: Mrs. Margaret W. Kuhl
(b) Address: 419 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-2-46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) Huntington Williams, M.D. (Data added by registrar) Registrar
30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 Oct. 1946, at 9.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Oct. 1946 to 30 Oct. 1946, and that I last saw h. alive on 29 Oct. 1946.

Immediate cause of death: CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION — Duration: —
Due to: SENILITY WITH SENILE DEMENTIA — —
Due to: FRACTURED RIBS AND FRACTURED TIBIA, LEFT, FROM — 25 DA.
Other Conditions: AUTOMOBILE ACCIDENT
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ACCIDENT
(b) Date of occurrence: 4 Oct. 46 at 9 00 P.M.
(c) Where did injury occur? BALTO. (City or town) BALTO. (County) MD. (State)
(d) Did injury occur about home, on farm, industrial place, in public place: CARTON & BENTALOU Rds. while at work? (Specify type of place)
(e) Means of injury: STRUCK BY CAR.
23. Signature: Robert W. Williams
Address: Franklin Sq. Hosp. Date signed: 29 Oct. 46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G15090

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 46a

Registered No. G15090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Sidney Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Williams, Howard Charles

3 (b) If veteran, name war

3 (c) Social Security Account No. 099-09-1901

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1884

8. AGE: Years	Months	Days	If less than one day
62	9	27	hr. min.

9. Birthplace Quogue, NY (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Louis Williams
13. Birthplace NY

MOTHER
14. Maiden Name Alvina Wrighter
15. Birthplace Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Richmond Hill
Location Long Island N. Y.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 31 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1946, to Oct. 30 1946, and that I last saw h alive on 19

Immediate cause of death Pneumonia, aspiration, bilateral — Duration Unknown

Due to Enlarged, Broadly fixed Conglomerating Carcinoma of the esophagus — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 27, 1946

Major findings of operation: P.O. stab gastrostomy 6 days

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul B. Walker
Address U. S. Marine Hosp. Baltimore 11, Md. Date signed 10/30/46 M. D.

VS 150

G15081 P.C. 4-60522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G15081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene + Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (Outside city limits write RURAL and give town)
(d) Street No. 4312 ~~Greene~~ University Hospital (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-24-46

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not given (refused)
13. Birthplace

MOTHER
14. Maiden Name Jessie Blackwell
15. Birthplace Virginia

16 (a) Informant Mrs Jessie Blackwell Gibson
(b) Address

17 (a) City disposal (Burial, cremation or removal) (b) Date thereof 10-25-46 (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 29 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 31 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1946, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1946, to 10-25 1946, and that I last saw h.i.m alive on 10-25 1946

Immediate cause of death Prematurity — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Dukes M. D.
Address University Hospital Date signed 10-25 1946

X

G15082 DC. G.60220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

G15082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 W Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy "B" Sutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	B	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-46

8. AGE: Years	Months	Days	If less than one day: hr.	min.
0	0	2		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation newborn.
11. Industry or business —

FATHER
12. Name Richard Sutton
13. Birthplace Winston Salem N.C.

MOTHER
14. Maiden Name Geneva Statum
15. Birthplace Winston, N.C.

16 (a) Informant Geneva Sutton
(b) Address 738 W. Franklin St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 29 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 31 1946 (Date rec'd by registrar) Hamilton Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1946, at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1946 to 10-24 1946 and that I last saw h.l.wt alive on 10-24 1946

Immediate cause of death Pneumonia

Duration

Due to Atelectasis

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Louis Jorgen M. D.
Address Hospital Date signed 10/24/46

G45083 YCH G60108

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 160a

G45083 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD- (b) County Anne Arundel
(c) City or town BALTIMORE - 25 - Md-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Brookwood Rd
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Macknavitz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-46

8. AGE: Years | Months | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md-
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Edward P Macknovitz

13. Birthplace

14. Maiden Name Alice Savitowicz

15. Birthplace

16 (a) Informant Edward P. Macknovitz
(b) Address 5105 Brookwood Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 29 1946

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 31 1946 (Date rec'd by registrar) Huntington Hillsdale MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1946, at 3:[illegible] P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1946, to 10-26 1946, and that I last saw him alive on 10-26 1946

Immediate cause of death Toxicity — Duration

Due to Erythroblastosis Fetalis

Due to

Other Conditions Jaundice

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Subgalgal & Subarachnoid Hemorrhage

of autopsy: Cong. Cystic Kidney Dz.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Guy H. Riggs M. D.

Address Union + Stone- Date signed 10-26-46

VS 150

F G15081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G15084

Every item of information should be carefully supplied. PRESS WRITE FIRMLY, WITH UNFADING INK. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4616½ Pall Mall Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4616½ Pall Mall Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHANNA CIZEK

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph Cizek
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 15, 1870

8. AGE: Years	Months	Days	If less than one day
76	4	13	hr. min.

9. Birthplace: Rolendurm, Austria (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Johan Mantsch
13. Birthplace: Austria

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Henry Becraft
(b) Address: 4616½ Pall Mall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 31 1946 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1946, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26/ 1946, to 10/28 1946 and that I last saw h CR alive on 10/28 1946.

Immediate cause of death	Duration
Arter.-Sclerotic Cardio Vasc. Disease	few years
Due to Coronary Thrombosis	4 days
Other Conditions Embolism	1 minute

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A A Weinsbock M. D.
Address 4602 S. Kk... Date signed 10/29/46

G15085 [illegible] Adenocarcinoma

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G15085

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State D C (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 Nichols Ave, S.E. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Delph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-45

8. AGE: Years	Months	Days	If less than one day
1	0 17 5	20	hr. min.

9. Birthplace Colo. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Everett E. Delph
13. Birthplace Ky.

MOTHER
14. Maiden Name Thelma Straw
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Salem
Location Glenarden, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1908 Eastern Place Washington, D.C.

OCT 31 1946 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1946, at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946, to Oct. 30 1946 and that I last saw h. alive on Oct 30 1946.

Immediate cause of death Respiratory failure — Duration

Due to Carcinoma - type undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Carcinoma - type ?

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Dorman, M.D. M. D.
Address Johns Hopkins Hosp. Date signed 10/31/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G15086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1486

Registered No. G15086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Berry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Berry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Lydard.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife James Lydard. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11 1862

8. AGE: Years	Months	Days	If less than one day
83.	10	16	hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Thomas Phillips.
13. Birthplace Md.

MOTHER
14. Maiden Name Harriet Appleby
15. Birthplace Md.

16 (a) Informant Walter R. Wheat.
(b) Address 703 Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31 1946 (month) (day) (year)
(c) Cemetery or crematory Howard's Chapel
Location near Mt Airy.

18 (a) Funeral director Shemwell & Donovan
(b) Address 645 W Lanvale Ave.

19 (a) (b) Registrar

OCT 31 1946 Huntington Mills, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27, 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1946 to 10/27 1946, and that I last saw h[illegible] alive on 10/27 1946.

Immediate cause of death	Duration
Uremia	
Intestinal Obstruction	
Due to carcinoma of uterus	
Due to with widespread metastases	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Townsend, M. D.
Address 14 E. Eager St Date signed 10/30/46

G45087 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 61 — Registered No. G45087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town 12 N. Patterson Pk Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. ____ (If rural give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3 (a) FULL NAME Emma M Muller

3 (b) If veteran, name war ____ | 3 (c) Social Security Account No. ____

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Henry A. Muller
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 4 - 1879

8. AGE: Years 67 | Months 4 | Days 27 25 | If less than one day: ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation ____

11. Industry or business ____

FATHER — 12. Name Jacob Hofmeister
13. Birthplace Ger.

MOTHER — 14. Maiden Name Barbara Letterer
15. Birthplace Baltimore

16 (a) Informant Mr. Henry Muller
(b) Address 12 N. Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 2 46 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) OCT 31 1946 (Date of this registration) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/46 1946 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1946 to 10/29 1946 and that I last saw her alive on 10/25 1946.

Immediate cause of death: Cardiac failure — Duration: ____
Due to: Cerebral Attack — Duration: 5 days
Due to: Bronchopneumonia — Duration: ____
Other Conditions: Diabetes Mellitus — Duration: ____
(Include pregnancy within 3 months of death)

Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature C. E. Lourie M.D.
Address Mt. Sinai Hospital Date signed 10/29/46

VS 150

122 C

G45088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 83B

G45088
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 Reisterstown Rd
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Pikesville Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Holden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) ~~Single~~, married, widowed, or divorced

6 (b) Name of husband or wife Daniel L. Holden 3rd

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) May 20 1909

8. AGE: Years 37 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)

10. Usual Occupation Nurse + Housework

11. Industry or business

FATHER 12. Name Oliver S. Holland

13. Birthplace Harford Co Md

MOTHER 14. Maiden Name Rosella Francis

15. Birthplace Balto Co Md.

16 (a) Informant Daniel L. Holden 3rd

(b) Address 204 Reisterstown Rd. Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1-46 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location Towson, Maryland

18 (a) Funeral director Frank H. Purrell

(b) Address Pikesville, Maryland.

19 (a) OCT 31 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1946, at 5 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 29 1946, and that I last saw her alive on Oct 29 1946.

	Duration
Immediate cause of death: Cerebral Embolism	5 min.
Due to: Septicemia	29 day
Due to: Staphylococcus Albus	39 day
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Southerick M. D.
Address Franklin Square Hosp. Date signed 10/29/46

Huntington Williams, M.D.

G15089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G15089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CATON & WILKENS AVES
(c) Hospital or institution: ST. AGNES HOSP. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MO
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. 5 10 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 McELDERRY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CONSTANTINE PIHAKIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MARY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day: hr.	min.
40	9			

9. Birthplace GREECE (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name JAMES PIHAKIS
13. Birthplace GREECE

MOTHER
14. Maiden Name MARY NICHOLAS
15. Birthplace GREECE Weirton W.Va.

16 (a) Informant Nick Pihakis
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-46 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd.

18 (a) Funeral director Lambros Inc.
(b) Address 440 E. North Ave.

19 (a) [illegible] (Date rec'd by reg.) Huntington Williamson, W.Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946, at 6:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1946 to Oct. 28 1946, and that I last saw him alive on 28 Oct. 1946.

Immediate cause of death	Duration
Intestinal obstruction	
Due to Carcinoma of rectum & generalized metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Aug 30, 1946 - Oct 25 1946
Major findings of operation: generalized carcinomatous metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Hoke Jr.
Address St. Agnes' Hospital Date signed 10/28/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 37c

G45090 Registered No. G45090

G45090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 67½ Winters Ave. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES ALLEN ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	N	MARRIED

6 (b) Name of husband or wife Archibald Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-1895

8. AGE: Years	Months	Days	If less than one day
51	3	23	hr. min.

9. Birthplace West Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name Joseph H Simms
13. Birthplace Va

MOTHER: 14. Maiden Name Cora Huggins
15. Birthplace Ohio

16 (a) Informant Archibald Allen
(b) Address 67½ Winters Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-46 (month) (day) (year)
(c) Cemetery or crematory Highland Park.
Location Cleveland Ohio.

18 (a) Funeral director Wm Frazier & Hemler
(b) Address 578 W Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 31 1946 VS No. Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1946, at 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1946 to 10/29 1946, and that I last saw her alive on 10/29 1946

Immediate cause of death: Encephalitis Lethargica — Duration: 15 days (?)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. F. Maloney -
Address Baltimore - 28 Date signed 10-30- M. D.
57 Winters Lane

G45091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G45091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 926 Argyle Ave. (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jashua Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER 12. Name Jashua Brown
13. Birthplace Md

MOTHER 14. Maiden Name Mary Gaither
15. Birthplace Md

16 (a) Informant Elizabeth Matthews
(b) Address 926 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Mrs Frances A Hemsley
(b) Address 578 W Biddle St.

19 (a) OCT 31 1946 (Date of death registered) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1946, at 630 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946, to Oct 29 1946, and that I last saw him alive on Oct 29 1946.

Immediate cause of death: Cardiac Failure
Due to: General Complication
Due to: Aortic Regurgitation

Duration
6 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J C Stewart M. D.
Address 632 W Franklin St Date signed 10/31/46

VS 150

Huntington Williams, M.D.

X

G45092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √43a

G45092 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1470 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1470 W. Pratt St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Spearman

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John J Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1868

8. AGE: Years 78 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Catherine M. Mouck

(b) Address 1605 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2-1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Balto City

18 (a) Funeral director Pratt C. B. M. Walter

(b) Address Pratt & Stricker Sts

OCT 31 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946 at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1946 to Oct 29 1946 and that I last saw h.e.r alive on Oct 29 1946

Immediate cause of death cerebral Hemorrhage — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen M. D.

Address 206 S. Gilmor St. Date signed 10-31-46

VS 150

X

G45093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45093 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 Penna Ave
(c) Hospital or institution:

14-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Penna Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Lane

3 (b) If veteran, name war /

3 (c) Social Security Account No. 213-03-2168

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56				

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Laborer-Fireman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. Fannie Jackson
(b) Address 1132 N. Fulton Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna, Ave,.

19 (a) NOV 3 1946 (Date rec'd by Registrar) (b) [illegible] for William Frey Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 19 46, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 19 46 to Oct 31 19 46, and that I last saw him alive on Oct 29 19 46.

Immediate cause of death Cardio Vascular Disease — Duration

Due to Broken Complication — 4 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. William Frey M.D.
Address 1428 Pa. Ave. Date signed 6-3-31

X

G15094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G15094 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 n Chaple st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 n Chaple st (If rural, give district)
(e) Citizen of foreign country? Chapel (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1860

8. AGE: Years 86 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Easton Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name John Charles Thomas
13. Birthplace md

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace md

16 (a) Informant Wesley Thomas
(b) Address 405 N. Chaple st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31. 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md

18 (a) Funeral director Chas T. Wilson
(b) Address 010 Bentley ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 31 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1946 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1946 to 10/27 1946.
and that I last saw alive on 10/27/1946.

Immediate cause of death: Bronchopneumonia
Due to (b) Myocarditis
Due to (c) Cold at Exposure

Duration: 1 wks, 60 dys

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J W Lake

Address 1327 N. Central Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Brennan

G15095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 Gibbons Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Gibbons Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Emma King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1878

8. AGE: Years	Months	Days	If less than one day
68	3	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Captain
11. Industry or business Balto Police Dept.

FATHER
12. Name John King
13. Birthplace Md.

MOTHER
14. Maiden Name Mary .
15. Birthplace Md.

16 (a) Informant Mrs. Mary E. King
(b) Address 2708 Gibbons Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) [illegible] (b) Date received OCT 31 1946 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Octo. 30, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Oct. 1946, and that I last saw him alive on Oct 10 1946.

Immediate cause of death Coronary Thrombosis — Duration

Due to Coronary Arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M.D.

Address 5217 Harford Rd Date signed 10-30-46

X

G45096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 56 D

G45096

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Baltimore 11, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Amity Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson, James Bernard

{ SUPPLEMENTARY COPY WILL FOLLOW ON RECEIPT OF MICROSCOPIC REPORTS. }

3 (b) If veteran, name war --

3 (c) Social Security Account No. 213-14-8416

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mildred Mack

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) October 23, 1922

8. AGE: Years 24 | Months 0 | Days 7 6 | If less than one day: hr. min.

9. Birthplace Charlotte, N. C. (Town, county, and state)

10. Usual Occupation S 2/c - U.S.Navy

11. Industry or business U.S.Navy

FATHER 12. Name Moses Nelson

13. Birthplace Columbia, S. C.

MOTHER 14. Maiden Name Lucille Pickett

15. Birthplace Columbia, S. C.

16 (a) Informant Records

(b) Address U.S.Marine Hospital, Balto.Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof [illegible] 4, 1946 (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St

19. (a) [illegible] (b) Registrar Huntington Willi[illegible]

OCT 31 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946 at 12:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1946 to Oct. 29 1946, and that I last saw him alive on Oct. 29 1946.

Immediate cause of death Unknown — Duration: [blank]

Due to meningioma — Duration: Unk

Due to — Duration: [blank]

Other Conditions Virus encephalomyelitis (Guillain Barre disease) — Duration: 17 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 10/30/46

G45097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. G45097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2352 Annapolis Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amos Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Susie Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1876

8. AGE: Years 70 Months 9 Days If less than one day hr. min.

9. Birthplace Howard Co. Md. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Stephelus Jackson
13. Birthplace Howard Co. Md.

MOTHER 14. Maiden Name Elizabeth Smith
15. Birthplace Howard Co. Md.

16 (a) Informant Benjamin Platt
(b) Address 2402 Annapolis Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem. Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) H. [illegible] Registrar

OCT 31 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1946 at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Broken Neck
Bronchopneumonia
Due to Senility & Arteriosclerosis

Other Conditions Hypertrophy - Prostate
7 hours
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mulligan M.D.
Medical Examiner.
Date signed 10-28-46

Write the causes of death clearly and legibly. Physicians: please write this especially important.

G15098 — BALTIMORE CITY HEALTH DEPARTMENT — G15098

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Gardens Apts 5-7, Balto
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry F. Lazarus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Mar

6 (b) Name of husband or wife Hattie L. Lazarus
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1876

8. AGE: Years	Months	Days	If less than one day
70	0	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Ferdinand Lazarus
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca Rosenthal
15. Birthplace Baltimore, MD.

16 (a) Informant Hillard Lazarus (Son)
(b) Address 927 Brooks Lane, Balto

17 (a) Burial (b) Date thereof 11/1/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~cremation~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harid Lowenstein & Son
(b) Address 1902 Eutaw Place

19 (a) [illegible] (b) Registrar

OCT 31 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1946, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1946, to 10-30 1946, and that I last saw him alive on 10-30 1946.

Immediate cause of death: Myocardial infarction — Duration 3 days.
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions Heart Block.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address Union Mem. Hosp. Date signed 10-30-46

X

G15099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G15099 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 446 N.Pat.Pk.Ave.
(c) Hospital or institution:

6-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 446 N.Pat.Pk.Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Capt. John George

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	216-01-0016

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1882

8. AGE: Years	Months	Days	If less than one day
64	4	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Herman George
13. Birthplace Pa.

MOTHER
14. Maiden Name Katherine Schick
15. Birthplace Balto. Md.

16 (a) Informant Mrs.Katherine George
(b) Address 446 N.Pat.Pk.Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov.2,1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date filed by registrar) (b) Huntingtown, Williams, Md.

OCT 31 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct.29/46 19 , at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to 10-29-1946 and that I last saw him alive on 10-29-1946.

Immediate cause of death	Duration
METASTATIC CARCINOMA	2 yrs.
Due to CARCINOMA OF PROSTATE	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Jones M. D.
Address 448 N. Luzerne Ave. Date signed 10-31-46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45100 • 170 C — Registered No. G45100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Guntner (GUENTHER)

3 (b) If veteran, name war ____ | 3 (c) Social Security Account No. ____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna M.C. Guenther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871, May 17

8. AGE: Years	Months	Days	If less than one day
75	4 5	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Adolph Guenther
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rose---
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Anna M.C. Guenther
(b) Address 823 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto. Md

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) OCT 31 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1946 at 6.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Rupture of Inferior Vena Cava
Intra pericardial Hemorrhage
Due to Broken back

Other Conditions Fractures of ribs, other fractures, contusions, brain, lungs & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-29-46 at 6.30 p. M. 7/3
(b) Where did injury occur? Monument & Patterson Pk. Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by B.T. Co. bus

23. Signature [illegible] Medical Examiner. M.D.
Date signed 10-30-46

VS 191

G45101 — BALTIMORE CITY HEALTH DEPARTMENT — G45101

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3319 Du Pont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 DuPont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank. J. Duggan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ida Duggan
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 5, 1877

8. AGE: Years	Months	Days	If less than one day
69	4	25	hr. min.

9. Birthplace Portsmouth, Va.
(Town, county, and state)
10. Usual Occupation Retired Coppersmith,
11. Industry or business Yeast Co.

FATHER
12. Name Patrick Duggan,
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ellen McManus,
15. Birthplace Va.

16 (a) Informant Mrs. Ida Duggan,
(b) Address 3319 DuPont Ave.

17 (a) burial (b) Date thereof 11/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave

19 (a) (Day reported by Registrar) (b) Registrar

OCT 31 1946 Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1946, at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1943, to 10-29 1946 and that I last saw h[illegible] alive on 10/29 1946

Immediate cause of death: Acute Cardiac Failure — Duration: 10a

Due to: Cardiovascular Renal disease — 3yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Lancaster, M.D.
Address 6 W Lafayette Ave Baltimore 1 Md. Date signed 10/31/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45102 BALTIMORE CITY HEALTH DEPARTMENT G45102
CERTIFICATE OF DEATH 46 H
Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 St. Ambrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADELE ABBOTT

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Everett B. Abott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1886

8. AGE: Years	Months	Days	If less than one day
59	10	5	hr. min.

9. Birthplace Emmittsburg Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Thomas C. Seltzer,
13. Birthplace Gettesburg, MH. Pa.

MOTHER
14. Maiden Name Marie Lansinger,
15. Birthplace Emmitsburg, Md.

16 (a) Informant Mr. E. B. Abbott,
(b) Address 3412 St. Ambrose Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director C. Vernon Lemman.
(b) Address 4611 Park Heights Ave.

19 (a) 10-31-1946 (Date filed by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1946, at 12:16 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946 to 10-29 1946, and that I last saw her alive on 10-28 1946

Immediate cause of death MYOCARDIAL FAILURE — Duration

Due to MULTIPLE THROMBOSES

Due to POST- OPERATIVE

Other Conditions RETRO PERITONEAL SARCOMA
(Include pregnancy within 3 months of death)

Date of operation 10-25-46

Major findings of operation: RETRO PERITONEAL SARCOMA

of autopsy: MULTIPLE THROMBOSES

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lerman M. D.
Address Sinai Hospital Date signed 10-30-46.

G15103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G15103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave. + Cold Spring Lane
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Ave. + Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PLATT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: David Platt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1860

8. AGE: Years 86 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: David —
13. Birthplace: Russia

MOTHER
14. Maiden Name: —
15. Birthplace: Russia

16 (a) Informant: Nathan Platt
(b) Address: 3910 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-46 (month) (day) (year)
(c) Cemetery or crematory: United Hebrew
Location: Wash. Blvd.

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1439 E. Balto St.

19 (a) [illegible] Registrar

Clayton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1946 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to 10-31 1946 and that I last saw h[illegible] alive on 10-31 1946.

Immediate cause of death: Coronary thrombosis — Duration

Due to: arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Henry Nagel

Address: Levindale Home Date signed: M. 10 D. 31 46

X

G45101 B.C. 9-62714 BALTIMORE CITY HEALTH DEPARTMENT ✓ G45101
CERTIFICATE OF DEATH
159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 in A. Hosp.
(c) Hospital or institution: E. Monument St 1500

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore-16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 W. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Gouline

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
MD.			4 hr. min.

9. Birthplace Balto. MD (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Gouline
13. Birthplace Balto., MD

MOTHER
14. Maiden Name Gloria Shapiro
15. Birthplace Balto., MD.

16 (a) Informant Mother
(b) Address 3001 W. Hilton St #16

17 (a) Burial (Burial, cremation, or removal) Date thereof 11-1-46 (month) (day) (year)
(c) Cemetery or crematory Beth Hilton
Location Windsor Mill Rd

18 (a) Funeral director Engle Lewis Inc
(b) Address 1439 E. Balto St

19 (a) OCT 31 1946 Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946 1946, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1946 to 10-31 1946, and that I last saw h.r alive on 10-31 1946

Immediate cause of death Respiratory failure

Due to Atelectasis

Due to Prematurity

Other Conditions Clubbed r. foot.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 11-3-46

correct age is especially important. Physicians: please write the

X

G45105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G45105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6321 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry B. Shadburn Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Cotta E Shadburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/20/92

8. AGE: Years	Months	Days	If less than one day
74	7	10	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Truck farmer
11. Industry or business

FATHER
12. Name Henry T. Shadburn
13. Birthplace Ga.

MOTHER
14. Maiden Name Araminda Light
15. Birthplace Ga.

16 (a) Informant Henry B. Shadburn
(b) Address 915 Elmhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto. Co. Md.

18 (a) Funeral director Langsdon Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 1 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1946, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1946, to 10-30 1946, and that I last saw him alive on 10-30 1946.

Immediate cause of death Regurgitation ceased. — Duration

Due to Pulmonary tuberculosis (not proven before autopsy)

Due to

Other Conditions Arteriosclerosis Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

(Contd.) of autopsy: Pulmonary tuberculosis, active

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Couch, M. D.
Address University Hosp. Date signed 10-31-46

G45106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45106 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 W. Fayette
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morgan Grace

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-09-6250

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Ann Grace | 6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 1875

8. AGE: Years: 71 | Months: 4 | Days: | If less than one day: hr. min.

9. Birthplace Hebbertsville Howard Co. Md. (Town, county, and state)

10. Usual Occupation Weaver

11. Industry or business Woolen Mill

FATHER
12. Name Joseph Grace
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Vernon Wiles
(b) Address 711 Savannah Ave Easton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland, Md.

18 (a) Funeral director Easton Home
(b) Address 608 Frederick Ave Easton

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 31 1946 Lexington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1946 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1945 to Oct. 29 1946, and that I last saw h[im] alive on Oct. 29 1946

Immediate cause of death: Coronary occlusion — Duration: months

Due to: Arteriosclerosis — 7

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jean A. Kortman M.D.

Address Ellicott City Md Date signed 10 Jan 46

G15107
503607.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 96

G15107
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Germantown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5334 Greene St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Lucy A. Reynolds.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Dr. Francis B. Reynolds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-20-74

8. AGE: Years	Months	Days	If less than one day
72.	6	11	hr. min.

9. Birthplace Mass.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jethro Ashley
13. Birthplace Mass.

MOTHER
14. Maiden Name Elizabeth Boyce
15. Birthplace Mass

16 (a) Informant Reconda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof 10/31/46 (month) (day) (year)
(c) Cemetery or crematory
Location Amenia, New York

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-05 E. Madison Street

19 (a) 1946 (b) Huntington Williamsville
Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946, at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1946 to Oct. 31 1946 and that I last saw h[illegible] alive on Oct. 31 1946.

Immediate cause of death
Post Operative Hemorrhage.
Duration 12 hours 6 mos.
Due to Cerebral aneurysm
Due to
Other Conditions Arteriosclerosis, generalized
(Include pregnancy within three months of death)
Date of operation Oct 30, 1946
Major findings of operations Cerebral aneurysm.
of autopsy Yes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Arthur M. King M. D.
Address Johns Hopkins Hosp. Date signed 10/31/46

Correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

G95108 ✓ G95108

501918

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

Registered No. 12418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town St. Petersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Sangorine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel J. Mac Dontosh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	married

6 (b) Name of husband or wife Dola M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-16-93

8. AGE: Years	Months	Days	If less than one day
53.	5	5	hr. min.

9. Birthplace Mass. (Town, county, and state)
10. Usual Occupation Salesman.
11. Industry or business

FATHER
12. Name Alexander Mac Intosh
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Cecelia McDougal
15. Birthplace Nova Scotia

16 (a) Informant Rec'nda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11-1-46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas. L. Schimunek
(b) Address 1601 E. Madison St.

19 (a) (Date rec'd by registrar) Huntington Willi... Registrar

NOV 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1946, at 11.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2. 1946, to Oct 21 1946, and that I last saw him alive on Oct. 21 1946.

Immediate cause of death	Duration
Cerebral Thrombosis ? Embolism	
Hepatorenal syndrome	
Due to Portal Cirrhosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/17/46
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Driscoll M.D.
Address Date signed 11/2/46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15109 BALTIMORE CITY HEALTH DEPARTMENT G15109
CERTIFICATE OF DEATH 54a
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County York
(c) City or town New Freedom
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abed Fry
3 (b) If veteran, name war
3 (c) Social Security Account No. 180-09-4098

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Mary Lerew
6 (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) July 2, 1896
8. AGE: Years 50 | Months 3 | Days 23 | If less than one day hr. min.
9. Birthplace Woodstock, Va. (Town, county, and state)
10. Usual Occupation Shipping clerk
11. Industry or business Plastic Mfg. Plant

FATHER
12. Name Charles L. Fry
13. Birthplace Va.

MOTHER
14. Maiden Name Rymon
15. Birthplace Va.

16 (a) Informant Mary L. Fry
(b) Address New Freedom, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory New Freedom
Location New Freedom, Pa.

18 (a) Funeral director Jacob Harlenstine
(b) Address New Freedom, Pa.

19 (a) (Signature of Registrar) (b) Registered Nov 1 1946
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1946 to Oct 31 1946 and that I last saw h.i.M. alive on Oct 31 1946

Immediate cause of death Resp. failure + pericardial effusion — Duration

Due to Intercranial Pressure

Due to Brain Tumor

Other Conditions Pneumonia - Lft lower lobe

(Include pregnancy within 3 months of death)

Date of operation Oct 29, 1946

Major findings of operation Decapsulation of Lft temporal lobe

of autopsy Confirmation of Lft temp. lobe

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert E. McCurdy
Address Redwood & Greene Date signed 10/31/46 M. D.

G45110 CWK-104465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G45110

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 17-
(e) Length of stay in Baltimore (yrs., mos., or days) 63- 5- 3-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2635 Greenmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Nau

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1883

8. AGE: Years	Months	Days	If less than one day
63	5	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Lineotype Operator
11. Industry or business Printer

FATHER
12. Name George Nau
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Kurn
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1946 to Oct. 29 1946, and that I last saw him alive on Oct. 29 1946.

Immediate cause of death	Duration
Coccidioidomycosis	
Due to Bronchogenic carcinoma.	
Due to	
Other Conditions Pneumonitis atelectasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. Gibbs M. D.
Address Balti. City Hospitals Date signed 11/1/46

G45111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G45111 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 E. 20th street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 E 20th street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lena J. Payne

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife: Wm. B. Payne
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 22, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	3	8		

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas J. Mundy
13. Birthplace Virginia

MOTHER
14. Maiden Name Mildred E. Preddy
15. Birthplace Virginia

16 (a) Informant Wm B. Payne
(b) Address 110 E. 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1-1946 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Maryland

18 (a) Funeral director Wm Cook Inc
(b) Address 1212 St Paul St

19 (a) (Date rec'd by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1946 at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1946 to Oct 30 1946, and that I last saw him alive on Oct 29 1946.

Immediate cause of death	Duration
CARCINOMATOSIS	6 MO
Due to CARCINOMA CERVIX	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fritz J Steinjan M. D.
Address 2700 Harford Rd Date signed Oct 30 1946

VS 150

G15112

BALTIMORE CITY HEALTH DEPARTMENT ✓ G15112 Registered No.

CERTIFICATE OF DEATH 83a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 923 S. Decker st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 S. Decker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Haas

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22nd 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	9	8		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Conrad Haas
13. Birthplace Germany

MOTHER
14. Maiden Name Madeline Klug
15. Birthplace Germany

16 (a) Informant Mrs Louis Kegel
(b) Address 923 S. Decker Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30th 1946 at 8 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1946 to Oct. 30 1946, and that I last saw h im alive on Oct. 30, 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	5 months
Due to Arterio-sclerosis	?
Due to Myocardial insufficiency	13 hrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Monmonier M.D.
Address 3037 O'Donnell St Date signed OCT 31 1946

Herrington Williams M.D.

J. A. Monmonier X

G45113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G45113
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-2
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charleston Apt. 201 Charles St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wheaton Pindell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Edna P. Pindell

6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1882

8. AGE: Years 64 Months 9 Days 2 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name DeWyvell Pindell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cora Wheaton
15. Birthplace Mississippi

16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 1 1946 (Date rec'd by registrar) (b) Hunting for William

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1946 at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1946 to Oct. 31 1946 and that I last saw h[illegible] alive on Oct. 30 1946

	Duration
Immediate cause of death: Cor pulmonale, chronic	3 yr.
Due to: Emphysema, chronic	7 yr.
Due to: Bronchial asthma	8 yr.
Other Conditions: Bronchitis chronic - sclerotic heart disease	5 yr.

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:

[illegible] of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Freeman Jr.
Address U.M.H Date signed 31 Oct 46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

AB-108205 945111 Registered No. G15114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 & 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Otterbein St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Lohman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1879

8. AGE: Years 67 Months 4 Days 16 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Mechanic

FATHER
12. Name Frederick (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Yearly
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) Date rec'd by NOV 1 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1946 at 1.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-19 1946 to 10-31 1946 and that I last saw him alive on 10-31 1946.

Immediate cause of death Cardiovascular failure.

Duration

Due to Hypertensive cardiovascular disease.

Due to

Other Conditions Decubital ulcer of back.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. K. Gibbs, M. D.
Address Balt. City Hospitals Date signed 11/2/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45115 BALTIMORE CITY HEALTH DEPARTMENT G45115
CERTIFICATE OF DEATH 469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Chevy Chase (If outside city or town limits, write RURAL and give town)
(d) Street No. 6313 Georgia Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Ethelyn Clarkson Chase

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Chester S. Chase
6 (c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) Jan. 9, 1901

8. AGE: Years	Months	Days	If less than one day
45	10	22	hr. min.

9. Birthplace St. Louis, Missouri (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business
12. Name Pearl E. Rigler
13. Birthplace St. Louis, Mo.
14. Maiden Name Lola H. Clarkson
15. Birthplace Little Rock, Ark.
16 (a) Informant Admission Slip
(b) Address Church Home & Hosp.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location
18 (a) Funeral director Wm. J. Ficker & Sons
(b) Address North & Penna. Ave.
19 NOV 1 1946 (b) Name read by registrar Huntington Williams M.D. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1946 to Oct 31 1946, and that I last saw her alive on Oct 31 1946.

Immediate cause of death Coronary thrombosis — Duration 8 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Oct. 31, 1946
Major findings of operation: Pancreatic tumor with cyst
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Leary Moore M.D.
Address Church Home & Hosp. Date signed Oct. 31 1946

VS 150

G45116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G45116 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County CARROLL
(c) City or town WESTMINSTER (If outside city or town limits, write RURAL and give town)
(d) Street No. E. MAIN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FLORENCE STANTON ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 8 1914

8. AGE: Years 32 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOUSE WORD.

11. Industry or business

FATHER
12. Name DANIEL STANTON
13. Birthplace [illegible]. LITHUANIA

MOTHER
14. Maiden Name MARY JESWOSKEY
15. Birthplace GERMANY

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 2 1946 (month) (day) (year)
(c) Cemetery or crematory WESTMINSTER CEMETERY
Location WESTMINSTER, MD.

18 (a) Funeral director JOHN R. BYERS
(b) Address WESTMINSTER, MD.

19 NOV 1 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1946, at 4:34 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1946, to 10/31 1946, and that I last saw HER alive on 10/31 1946.

Immediate cause of death: BRONCHOPNEUMONIA — Duration: 1 DAY
CONGESTIVE HEART FAILURE
Due to INSULIN SHOCK
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD. GEN. HOSP. Date signed 10/31/46

VS 150

X

G15117

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
JOHNSTON HOSPITAL

X 159

Registered No. G15117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St
(c) Hospital or institution:
Union Memorial Hospital, Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town ~~Baltimore~~ New Haven Conn.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Ferry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Buterac

3 (b) If veteran, name war: 0
3 (c) Social Security Account No. 0

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-24-46

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation baby
11. Industry or business 0

FATHER
12. Name ~~Robert E. Fitzgerald~~ Frank Paul Buterac
13. Birthplace

MOTHER
14. Maiden Name Julia Fitzgerald.
15. Birthplace Conn.

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Registered by) (b) Huntington Williams, M.D.
NOV 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1946; at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1946, to 10-29 1946, and that I last saw him alive on 10-29 1946.

Immediate cause of death — Duration
Respiratory failure
Due to
Due to
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Katharine Sprunt
Address Union Memorial Hosp. Date signed 10-29-46 M. D.

VS 150

X

G15118 BALTIMORE CITY HEALTH DEPARTMENT G15118

CERTIFICATE OF DEATH 1172

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-4
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Mc Culloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beatrice Harding

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Lark
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Princeton West Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Benjamin Henderson
13. Birthplace West Va.

MOTHER
14. Maiden Name Rody Crockett
15. Birthplace West Va.

16 (a) Informant H. S. Moses, Jr.
(b) Address 1216 Irvin St. Wash. D. C. N. W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory Wash. D. C.
Location

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St.

19 (a) NOV 1 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1946, at 12.15 P M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to hep death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured duodenal ulcer with peritonitis
Due to
Other Conditions Portal cirrhosis of liver Esophageal varices.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/31/46

G15119 MOORE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15119

Please write the causes of death clearly and legibly. Physicians are required by law to report promptly all deaths coming to their knowledge.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 746 W. HAMBURG ST.
(c) Hospital or institution: 9/1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 746 W. HAMBURG ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Moore

3 (b) If veteran, name war: WORLD WAR I

3 (c) Social Security Account No. 569-03-4518

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARY MOORE

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) MAY 8, 1894

8. AGE: Years 52 | Months 5 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace OHIO (Town, county, and state)

10. Usual Occupation BARBER

11. Industry or business

FATHER
12. Name JASPER MOORE
13. Birthplace OHIO

MOTHER
14. Maiden Name BESSIE BOGGS
15. Birthplace UNKNOWN

16 (a) Informant MARY MOORE
(b) Address 746 W. HAMBURG ST.

17 (a) BARIAL (Burial, cremation, or removal) (b) Date thereof 10-4-46 (month) (day) (year)
(c) Cemetery or crematory MEDOWRIDGE MEMORIAL PARK
Location WASHINGTON BLVD.

18 (a) Funeral director AMBROSE, INC.
(b) Address 1644 N. FRANKLINTOWN RD

19 (a) (Date rec'd by registrar) NOV 1 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/46 19 , at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner.

Date signed 10/30/46

VS 151

G15120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1246

Registered No. G15120

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4308 Maine Ave
(c) Hospital or institution: at Home DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Maine Ave
(If Rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Osborne Stall

3 (b) If veteran, name war: none

3 (c) Social Security Account No. [illegible]

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jennie Lynch Hall

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct. 22/1869

8. AGE: Years 77 | Months 0 | Days 7 | If less than one day: hr. min.

9. Birthplace Cecil Co. Md. (Town, county, and state)

10. Usual Occupation C.P.A.

11. Industry or business Self

FATHER
12. Name James J. Stall
13. Birthplace New Jersey

MOTHER
14. Maiden Name Annie Rothwell
15. Birthplace Cecil Co. Md.

16 (a) Informant Mrs Jennie L. Hall (wife)
(b) Address 4308 Main Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-1-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Mcguire Co.
(b) NOV 1 1946 8 W North Ave.

19 (a) [illegible] Pittsburgh Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946 to Oct 29 1946 and that I last saw h alive on Oct 29 1946

Immediate cause of death: Kidney Failure — Duration

Due to Chronic Nephritis

Due to Chronic Myocarditis (old coronary disease)

Other Conditions Contributing Cirrhosis of liver.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos G Abbott M. D.
Address 4509 Liberty Heights Ave. Date signed 10-30-46

131 B

VS 150

G15121

CMK-103031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 518

Registered No. G15121

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 11-
(e) Length of stay in Baltimore (yrs., mos., or days) 70- 0- 2-

3-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Stiles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Nicoll

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28-1876

8. AGE: Years	Months	Days	If less than one day
70	0	2	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Benjamin Nicoll
13. Birthplace ?

MOTHER
14. Maiden Name Cassandra
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (H. F. MOWEN SON.) 100 N. NORTH AVENUE

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 19 46 at 2:26 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 19 46 to Oct. 30 19 46, and that I last saw h. im alive on Oct. 30 1946.

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions Carcinoma of prostate with metastasis.
(Include pregnancy within 3 months of death)

Date of operation 8/14/1946

Major findings of operation: Carcinoma of prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Gibbs M. D.
Address Balto. City Hospitals Date signed 10/31/46

Huntington Williams M.D.

G15122 — BALTIMORE CITY HEALTH DEPARTMENT — G15122

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 Warner St
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 h

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl LICHTER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Davy Lichter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation Married Wife
11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Davy Lichter
(b) Address 1601 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-46 (month) (day) (year)
(c) Cemetery or crematory New Hebrew Cem
Location

18 (a) Funeral director Jack Levine Bro
(b) Address 1739 E Baltimore St

19 (a) Date rec'd by reg'r NOV 1 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1946, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Nov 1 1946, and that I last saw h e alive on Oct 30, 1946

Immediate cause of death	Duration
Acute congestive heart failure	1 hr
Due to Hypertension	30 yrs
Due to Arterio sclerosis	30 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jack Cohen M. D.
Address 186 Eutaw Place Date signed 11/1/46

X

G15123 BC# G39458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G15123
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO
(c) City or town BALDWIN
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME WARREN JAMES CHANDLER HILFERTY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 6, 1946

8. AGE: Years	Months	Days	If less than one day
	10 9	24	hr. min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

FATHER 12. Name EDWARD F. HILFERTY

13. Birthplace PENNA

MOTHER 14. Maiden Name CATARINE CHANDLER

15. Birthplace PENNA

16 (a) Informant CATARINE CHANDLER

(b) Address BALDWIN, MD.

17 (a) Burial (b) Date thereof Nov 1/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Fork Cemetery
Location Fork, Md.

18 (a) Funeral director John O. Mitchell Sons

(b) Address 1900 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 1 1946 Carrington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Oct. 1946 19 2.55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Oct. 1946 to 30 Oct 1946, and that I last saw him alive on 30 Oct 1946.

Immediate cause of death	Duration
Cardiac failure (Congestive failure)	24 hrs.
Due to Congenital Heart	10 mos.
Due to disease interventricular septal	10 mos.
Other Conditions defect.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Interventricular septal defect.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold K. Cooper M.D.

Address Union Memorial Date 30 Oct 1946

Stamp X

G15121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G15121 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert ST.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3715 Nortonia Road City (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Rhoda Anna Noffman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1892.

8. AGE: Years	Months	Days	If less than one day
54	11 4	10 20	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Teacher.

11. Industry or business

FATHER 12. Name Eugene E. Noffman.

13. Birthplace Maryland.

MOTHER 14. Maiden Name Bertha Vandenberg.

15. Birthplace Holland

16 (a) Informant Geo. A. Hoffman

(b) Address 3322 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Presbyterian Cem. Location Towson Md.

18 (a) Funeral director John C. Mitchell & Sons

(b) Address 1908 Eutaw Place

19 (a) NOV 1 (Date rec'd by Registrar) (b) 1946 Burial Permit

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1946, at 7:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1946, to Oct. 31 1946 and that I last saw her alive on Oct. 31 1946

Immediate cause of death: Adenocarcinoma of Sigmoid Colon with — Duration

Due to metastasis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M. D.

Address Union Memorial Hospital. 33rd & Calvert St. Date signed 10-31-46

VS 150

G15125

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 164c

Registered No. G15125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. High Acres
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Whitfield Owens Jr.

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No. 218-18-5614

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 26 1922

8. AGE: Years 24 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county and state)

10. Usual Occupation Law Student

11. Industry or business

FATHER
12. Name John W. Owens
13. Birthplace A. A. Co. Md

MOTHER
14. Maiden Name Virginia Dashiell
15. Birthplace Balto Md

16 (a) Informant A. Chesley Wilson
(b) Address 100 W University Pkwy

17 (a) Burial (b) Date thereof Nov 2 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Woodlawn, Balto Co

18 (a) Funeral director Henry H. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) NOV 1 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 19 46, at M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet-wound of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found dead at 11 AM. 10/31/46
(b) Where did injury occur? 716 Park Ave., Balto.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
Means of injury Revolver - shot through roof of mouth
Signature George L. Merrill M.D. Medical Examiner.
Date signed 10/31/46

X

G45126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓15

G45126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-1
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie May Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 1930

8. AGE: Years 16 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wesley Garner
13. Birthplace S C

MOTHER
14. Maiden Name Queenie Pugh
15. Birthplace S C

16 (a) Informant Wesley Garner (?)
(b) Address 720 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) NOV 1 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION 7.45

20. DATE OF DEATH Oct. 30, 1946, at 8. M

21. I certify that I took charge of the remains described above, held an insp.ing. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculous peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/30/46

G35127 Died 10-19-46 B.C. 58350

Hospital Disposal TN. 58350 105192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G35127

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4? 1946

8. AGE: Years | Months | Days 1 week ? | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Davis

13. Birthplace Columbia, S.C.

MOTHER 14. Maiden Name Nellie Mae Lumpkin

15. Birthplace Lee, Georgia

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof Oct/26/46 (month) (day) (year)

(c) Crematory Baltimore City Hospitals

Location 4940 Eastern Ave (Records)

18 (a) Funeral director

(b) Address

19 (a) (State record in cemetery) (b) Huntington Williams, Balto, Md.

NOV 1 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19/ 1946 19 , at 8.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct /12/ 1946 to Oct 19/ 1946 and that I last saw her alive on Oct /19 1946

Immediate cause of death	Duration
Prematurity	life
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.

Address Balto. City Hosp. Date signed Oct 24 1946

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15128 Hospital Disposal BCHD 58490 BALTIMORE CITY HEALTH DEPARTMENT G15128

TI. 105113 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy (Garris (Betty)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8th 1946

8. AGE: Years | Months | Days 13 Days | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Betty Lee Garris
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof Oct 26/1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 Filed by registrar Hunter for Williams NOV 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20/ 1946, at 9.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8/ 1946 to Oct20/ 1946 and that I last saw h im alive on Oct 20/ 1946.

Immediate cause of death Diarrhea — Duration 2 da

Due to Prematurity — Duration life

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E Hughes M. D.
Address Balto City Hosp Date signed Oct 27, 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G15129 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

HB # 104643

CERTIFICATE OF DEATH

119a

Registered No. G15129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 14-1
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Boy-Rubenstien (Florence)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	New born Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1946

8. AGE: Years	Months	Days	If less than one day
	1	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Joseph Rubenstien
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Florence McKinney
15. Birthplace Baltimore Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof Oct/26/46 (month) (day) (year)
(c) [redacted] crematory 4940 Eastern Ave
Location Baltimore City Hospitals (Records)

18 (a) Funeral director
(b) Address

19 (a) NOV 1 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1946 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1946 to Oct. 21, 1946, and that I last saw him alive on Oct. 21, 1946.

Immediate cause of death	Duration
Malnutrition +	2 wks
Sepsis + Dehydration	
Due to Diarrhea	3 wks
Due to Prematurity	Life
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes
Address Balto City Hosp Date signed Oct 26 '46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Hospital Disposal BCH BALTIMORE CITY HEALTH DEPARTMENT ✓ G35130

CHK-104818 58617 CERTIFICATE OF DEATH 119a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Diver Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Robertson, Mamie-Mother ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27-1946

8. AGE: Years	Months	Days	If less than one day
0	0	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Paul John Robertson
13. Birthplace West Virginia

MOTHER 14. Maiden Name Mamie Lovill
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof October 26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Name of crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 NOV 1 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 24 19 46 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 19 46 to Oct. 24 19 46, and that I last saw h. im alive on Oct. 24 19 46.

	Duration
Immediate cause of death Malnutrition, Dehydration & Sepsis	10 da
Due to Prematurity	19 da
Due to	life
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp Date signed Nov 6 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G15131 ✓ G15131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 E. Eager St
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda L. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Willie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1901

8. AGE: Years 45 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Cumberland County Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Shavers

13. Birthplace Va.

MOTHER 14. Maiden Name Ann Epps

15. Birthplace Va.

16 (a) Informant Willie Harris

(b) Address 1503 E Eager St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 1 '46 (month) (day) (year)

(c) Cemetery or crematory

Location Farmville Va.

18 (a) Funeral director Mrs Cliff J. Elliott, Jr.

(b) Address 429 N. Caroline St.

(Signature or Initials of Registrar)

NOV 1 1946 (Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 30 1946 and that I last saw h[illegible] alive on Oct 29 1946

Immediate cause of death	Duration
Malignant Hypertension	
Due to Arteriosclerosis	
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard S. Trunk M.D.

Address 2879 Arunah Date signed 10/31/46

VS 150

X

G15132 BALTIMORE CITY HEALTH DEPARTMENT G15132
CERTIFICATE OF DEATH 13a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Brune St 17-3
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Brune St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry Hough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Victoria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1875

8. AGE: Years 70 71 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Bethune S. C. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Ben Hough
13. Birthplace S. C.

MOTHER
14. Maiden Name Matilda ?
15. Birthplace S. C.

16 (a) Informant Rosa Lee
(b) Address 708 Brune St

17 (a) Remodal (Burial, cremation, or removal) (b) Date thereof Nov 14 (month) (day) (year)

(c) Cemetery or crematory
Location Bethune S. Carolina

18 (a) Funeral director Mrs. O. H. Gilliard & Son
(b) Address 1129 N. Carolina St

19 (a) NOV 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1946 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Oct 29 1946 and that I last saw h alive on Oct 29 1946

Immediate cause of death — Duration
Cardio Renal Disease — 3 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Paul E. Patterson M. D.
Address 2329 Druid Pk Date signed Nov 1 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G15133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Hilkens Ave
(c) Hospital or institution:
St. Agnes Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred T. Breitengross

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Cordelia Breitengross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business St. Mary's Industrial School

FATHER
12. Name -
13. Birthplace Germany

MOTHER
14. Maiden Name -
15. Birthplace Germany

16 (a) Informant Mr. George Rukert
(b) Address 2320 W. Lanvale St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Salem Cem.
Location Orwigsburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1946, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1946, to 10/31 1946, and that I last saw him alive on 10/31 1946.

Immediate cause of death Cardiac failure Duration
H.C.V.D.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald W. Munter M. D.
Address St Agnes Date signed

correct age is especially important. Physicians: please write the

VS 150

G45134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G45134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Braddish Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN L. ENGEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Carrie H.Engel(Nee Spicker)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1887

8. AGE: Years	Months	Days	If less than one day
58	11	21	hr. min.

9. Birthplace Baltimore (State, county and state)

10. Usual Occupation Plumber

11. Industry or business H. E. Crook Co.

FATHER
12. Name Wm. H. Engel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Gussie M. Twell
15. Birthplace Balto.

16 (a) Informant Mrs. Carrie H. Engel, wife
(b) Address 1618 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/46 19 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on 10/31 19 46

Immediate cause of death: Cardio-vascular failure — Duration

Due to Severe malnutrition

Due to Embolism Pulmonary

Other Conditions Cerebral Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Postmortem Examination

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph A. Nicholas, M.D.

Address Union Hosp. Date signed 11/2/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150 1946 Huntington Williams, M.P.

X

G15135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44B

Registered No. G15135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto.
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7000 Alden Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Jacobs Pistel

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-10-6878

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Ernestine F. Pistel | 6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 3, 1891

8. AGE: Years: 55 | Months: 7 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Inspector

11. Industry or business: Koppers Co.-200 Scott St.

FATHER
12. Name: William E. Pistel
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Barbara Eckstein
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Hospital Records
(b) Address: Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/2/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1946 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1946 to Oct. 30 1946, and that I last saw him alive on Oct. 30 1946.

Immediate cause of death: Hodgkin's Disease — Duration: 11 mths

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: H. R. Freeman Jr. M.D.
Address: U. M. H. Date signed: Oct 30/46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

BALTIMORE CITY HEALTH DEPARTMENT X V

G45136 **CERTIFICATE OF DEATH** 1338 Registered No. G45136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. R F D #5, Owynn Oak Station (If rural give location) Zone 7
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Becraft

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Widowed.

6 (b) Name of husband or wife Bessie King Becraft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1864

8. AGE: Years	Months	Days	If less than one day
82	5	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Truck Farmer
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Clarence E. Becraft
(b) Address Gaithersburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1946, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1946, to 10-31 1946, and that I last saw h[illegible] alive on 10-30 1946.

Immediate cause of death: Cardiac Failure — Duration

Due to Terminal pneumonia.

Due to renal damage

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Vaughan, Jr. M. D.
Address Univ. Hospital Date signed 10-31-46

VS 150

X

Please answer items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 in ink. Every item should be answered or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15137 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G15137

CERTIFICATE OF DEATH

72a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3322 McElderry St
(c) Hospital or institution: Sinai Hospital 2 6 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. KIRBY

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-8288

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
F	W.	

6 (b) Name of husband or wife CHARLES E. KIRBY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8- 1876

8. AGE: Years	Months	Days	If less than one day
69	11	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business J. P. Frieze Co.

FATHER
12. Name Andrew Cunningham
13. Birthplace Md

MOTHER
14. Maiden Name Sarah E Huggles,
15. Birthplace Md

16 (a) Informant Charles E Kirby
(b) Address 3322 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Rendell E Humphreys
(b) Address 6067 Harford Rd

NOV 1 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Oct 1946, at 3 07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Sept 1946, to 29 Sept 1946, and that I last saw h.e.r. alive on 29 Sept 1946.

Immediate cause of death	Duration
Pneumonia & overwhelming toxemia	24hrs.
Due to	
Due to	
Other Conditions Purpura	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley N. Yaffe M. D.
Address Sinai Hosp. Date signed 29 Oct.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G15138 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution: Lyndenbaum Hospital 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs 11 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 West Monument
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Elizabeth Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12 1936

8. AGE: Years	Months	Days	If less than one day
9	11	19	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Earl Sylvester Johnson
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Pearl Hickman
15. Birthplace Baltimore Md

16 (a) Informant Pearl Hickman Johnson
(b) Address 713 West Monument St.

17 (a) Burial (b) Date thereof 11-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hunsley
(b) Address 548 W Biddle St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1946, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1946, to Oct 31 1946, and that I last saw her alive on Oct 31 1946.

Immediate cause of death	Duration
Lobar Pneumonia	4
Left Lower Lobe	
Due to	
Due to	
Other Conditions Rheumatic Heart Disease	5 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature]
Address Lyndenbaum Hosp Date signed Oct 31, 46 M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1946 Huntington Williams, M.D.

X

G15139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

✓ G15139 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-9
(c) Hospital or institution: MD GENL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore # 11 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2136 Mt Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT L. TAYLOR. Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife Frances E.
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1877

8. AGE: Years	Months	Days	If less than one day
69.	8	7	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jackson Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Headdy Parks
15. Birthplace Virginia

16 (a) Informant Robert Lee Taylor Jr.
(b) Address 2136 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F Denny Inc
(b) Address 745 Light St.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1946, at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1946 to 10-29 1946, and that I last saw him alive on 10-29 1946.

Immediate cause of death: Respiratory FAILURE — Duration

Due to Cerebral Anoxia

Due to Arteriosclerosis

Other Conditions FRACTURE LEFT FEMUR (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15-9
(a) Accident, suicide, or homicide
(b) Date of occurrence 10/18/46 at 7:30 AM
(c) Where did injury occur? Home - Balto md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall floor bathroom

23. Signature Geo A Blackwell M. D.
Address Med Gene Hosp. Date signed 10-29-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 1 1946

Wm. Helfrich MD / per E.B. Merrill MD

Geo. A. Blackwell

G15140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

Registered No. G15140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 S. Carey St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 S. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN RISCH or RISKO

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-1138

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Julia Risch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Russian (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Clothing

FATHER
12. Name ? Risch
13. Birthplace Russian

MOTHER
14. Maiden Name Not know
15. Birthplace Russian

16 (a) Informant Mrs Julia Rusch
(b) Address 906 S. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-46 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Frederick Avenue

18 (a) Funeral director John A Grebiankes Jr
(b) Address 423 S. Paca St

19 (a) 11-1 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1946 at 6A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Sep 1946 to 31 Oct 1946 and that I last saw h alive on 30 Oct 1946

Immediate cause of death Bronchial Asthma — Duration 1 YEAR

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Phelan MD M.D.

Address 630 Washington Blvd Date signed 11-2-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

X

G15111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G15111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S. Decker Ave
(c) Hospital or institution? 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Fleischman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fred. Fleischman

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1880

8. AGE: Years 66 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Horner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Brigid Gorman
15. Birthplace Baltimore Md.

16 (a) Informant Fred. Fleischman
(b) Address S. S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-46 (month) (day) (year)
(c) Cemetery or crematory Lakewood Cem.
Location Taylor Ave

18 (a) Funeral director John E. Mulloy
(b) Address 2435 E. Oliver St.

19 (a) 11-1-1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 '46 to Oct 31 '46 and that I last saw h alive on 19

Immediate cause of death: Carcinoma Liver & Gall Bladder — Duration: Few

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation Sept 5 - 46

Major findings of operation Carcinoma Liver & Gall Bladder

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Hitzig M.D.
Address 1716 E 33rd St Date signed 10/31/46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G15112

Write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1137 Battery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N Charles St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine M. Walterspiel (Walterspiel)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-6645

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 - 1918

8. AGE: Years 28 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Office

11. Industry or business C. & P. Telephone Co.

FATHER
12. Name Frank Walterspiel
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ida Brecht
15. Birthplace Baltimore Md.

16 (a) Informant Ida Steinhice
(b) Address 1306 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2 - 46 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Cross Cem.
Location Ritchie Highway A.A. Co. Md.

18 (a) Funeral director Elizabeth Hart Inc.
(b) Address 115 E. West St.

19 (a) NOV 1 1946 (Date rec'd by Registrar) (b) Huntington W. Va. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1946 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 19 to 10/30 1946 and that I last saw h[er] alive on 10/27 1946

Immediate cause of death: Advanced Bilateral Pulmonary Tbc and Cavitation

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 Yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Ellison, M. D.

Address 107 E. West St Date signed 11/25/46

G15143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

× 939 ✓

Registered No. G15143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address The Seton Institute
(c) Hospital or institution: 6420 Reistertown Road
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs 23da
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs+

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Peabody (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brother Thaddeus Powers (JAMES POWERS)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 29 1877

8. AGE: Years	Months	Days	If less than one day
69	6	2	hr. min.

9. Birthplace Peabody, Mass. (Town, county, and State)
10. Usual Occupation Religious teacher
11. Industry or business

FATHER
12. Name James Powers
13. Birthplace Ireland

MOTHER
14. Maiden Name Honora Johnson
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar Huntington Williams M.D.

NOV 1 1946

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1934 to Oct 30 1946, and that I last saw h.. alive on Oct 30 1946.

Immediate cause of death	Duration
Cardiovascular collapse	
arteriosclerosis (3 days)	
Due to	
Due to	
Other Conditions Manic depressive psychosis - mixed type	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel P. Magee M. D.
Address 336 Cathedral St. Date signed

X

Please write plainly; avoid abbreviations. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Burial Certificate
B-G45142
G15144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ G15144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Westernald Ave.
(If rural give location)
(e) Citizen of foreign country? ND (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl McCardell (Susan Lee)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Oct 30 1946

8. AGE: Years	Months	Days	If less than one day
		1	6 hr. 50 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name William Kenneth McCardell
13. Birthplace Balto Md
14. Maiden Name Margaret M. McLaughlin
15. Birthplace Balto Md.

16 (a) Informant Father
(b) Address 3300 Westernald Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Manuson.
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Huntington Hollins (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1946 at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1946 to Oct 31 1946 and that I last saw HER alive on Oct 31 1946.

Immediate cause of death	Duration
Atelectasis Bilateral	
Due to Premature Infant born of Eclamptic Mother	
Due to Mother had been unconscious from paraldehyde 24 hours prior	
Other Conditions To delivery	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry T. Wilson Jr. M. D.
Address St. Joseph's Hospital Date signed Nov 1, 1946

VS 550 NOV 1 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

G45115 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address SARATOGA AND CALVERT
(c) Hospital or institution: MERCY HOSPITAL 25-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 DA
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 SYDNEY AVE. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SACKALOSKY. (SOKOLOTSKY)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1872

8. AGE: Years 74 | Months 4 3 | Days 22 | If less than one day hr. min.

9. Birthplace LITHUANIA (Town, county, and state)
10. Usual Occupation UNEMPLOYED.
11. Industry or business

FATHER
12. Name GEORGE SACKALOSKY.
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name HERSELJEBROSKUTIA
15. Birthplace LITHUANIA

16 (a) Informant A. Sackaloskey
(b) Address 2254 Sydney Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltic Rd

18 (a) Funeral director Joseph Kasmakes
(b) Address 60 E Washington

19 NOV 1 1946 (b) Hastings for Williams
Date rec'd by reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1946, at 7 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1946 to 10-30 1946 and that I last saw h/she alive on 10-30 1946.

Immediate cause of death PERIPHERAL VASCULAR COLLAPSE. | Duration

Due to CARCINOMA TONGUE. WITH METASTASIS.

Due to

Other Conditions ANEMIA, CACHEXIA, EMACIATION
(Include pregnancy within 3 months of death)

Date of operation 10-10.

Major findings of operation: WIDESPREAD EXTENSION OF CANCER.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(d) Means of injury

23. Signature James A. Robate M. D.
Address Mercy Hospital Date signed 10-30-46

Please write plainly, with ONE ENTRY ONLY in each space. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-1
(c) Hospital or institution: Johns Hopkins Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Littleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8/1885

8. AGE: Years	Months	Days	If less than one day
61 62	7	23	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name Fred. Fleury
13. Birthplace Md.

MOTHER
14. Maiden Name Sophie Myers
15. Birthplace Md

16 (a) Informant Julia Markwitz
(b) Address 3006 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Selby & Sons
(b) Address 403 S. Broadway

19 (a) (Date rec'd by registrar) NOV 4 1946 (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1946, at 9:25P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy/Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/1/46

G15117
AB-93920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G15117
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5- & 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Kiwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Muller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28- 1869

8. AGE: Years	Months	Days	If less than one day
77	2	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bloxie
13. Birthplace ?

MOTHER
14. Maiden Name Wilhemina ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11 F 1 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lily Redeman
Location Belair Rd

18 (a) Funeral director Lilly & Redeman
(b) Address 403 S Bolye Ave

19 (a) (Date rec'd by registrar) (b) Huntington Hobbins M.D.
(Address)

NOV 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1946 to 10-31 1946, and that I last saw him alive on 10-31 1946.

Immediate cause of death: Lobar Pneumonia, Rt. — Duration 1 week

Due to

Due to

Other Conditions Emphysema arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 11/1/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15118 — BALTIMORE CITY HEALTH DEPARTMENT — G15118

CERTIFICATE OF DEATH 1937

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2517 Gough St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2517 Gough St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hiram A Spence

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma Spence
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 6. 1880
8. AGE: Years 66 Months 7 Days 25 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Superintendent
11. Industry or business

FATHER
12. Name Wilhom Spence
13. Birthplace Ga

MOTHER
14. Maiden Name Mary Chambers
15. Birthplace Md

16 (a) Informant Wilhom D Spence
(b) Address 2503 Gough St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory Laurel Hill Columbia Pa
Location Columbia Penna

18 (a) Funeral director William Booth Jr
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1946, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1941 to Oct 31 1946, and that I last saw h alive on Oct 30 1946.

Immediate cause of death: Arteno-sclerotic C.V. Disease
Myocardial decompensation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johns H Gordon
Address 4400 E Oldo Dr Date signed 11/1/46

G15149 G15149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5200 Alhambra Ave
(c) Hospital or institution: 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5200 Alhambra Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. Burkman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband Frederick S Burkman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25th 1880

8. AGE: Years	Months	Days	If less than one day
66	1	2	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William H. Ellis
13. Birthplace Kirkwood

MOTHER
14. Maiden Name Sophia Butler
15. Birthplace Md

16 (a) Informant Frederick Burkman
(b) Address 6 South D. St. Glenburnie Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 1 1946 (b) (Registrar's number) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1946, at 3 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 27th 1946 to Oct. 30 1946, and that I last saw her alive on Oct 30 1946

Immediate cause of death: Coronary Occlusion — Duration: 3 days

Due to: Arteriosclerotic cardiovascular disease — Duration: 10 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J Thomas M. D.
Address 4600 York Rd Date signed 11/1/46

VS 150

237 G15150

G15150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1201B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-6
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn De Witt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles De Witt III

6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): 4-14-12

8. AGE: Years: 34 Months: 6 Days: 17 If less than one day: hr. min.

9. Birthplace: Maryland (Balto.)
(Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: John Chesler
13. Birthplace: Maryland (Balto.)

MOTHER
14. Maiden Name: Anna Andersen
15. Birthplace: Maryland

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Mausoleum
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 1 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1946, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1946, to 10-31 1946 and that I last saw h[illegible] alive on 10-31 1946.

Immediate cause of death: Toxemia + Eclampsia — Duration:

Due to: Ulcerative colitis (non-specific)

Due to:

Other Conditions: Hysterectomy

(Include pregnancy within 3 months of death)

Date of operation 10-28-46

Major findings of operation: †

of autopsy: Confirms

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Wm. J. Sheard M.D.
Address: Johns Hopkins Hosp. Date signed 10/31/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

† [illegible]

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

G15151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G15151 Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3719 Kimble Road
(c) Hospital or institution: 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3719 Kimble Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Bond Harris

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Robert L. Harris
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1883

8. AGE: Years	Months	Days	If less than one day
63	2	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business Home

FATHER
12. Name William Christopher
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary L. Bond
15. Birthplace Baltimore

16 (a) Informant Robert L Harris
(b) Address 3719 Kimble Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 1 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M. D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1946, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Nov 1 1946, and that I last saw her alive on Nov 1 1946.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Arterio sclerosis	10 years
10% per tension	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Gluck M. D.
Address 715 Park ave Date signed 11/4/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15,152 V117a G15,152 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-3
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Dorton Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Taylor Parsons

3 (b) If veteran, name war NO. | 3 (c) Social Security Account No. NO.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robert J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 8. 1918

8. AGE: Years 28 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation Lawfe.

11. Industry or business

FATHER 12. Name Aubrey Taylor
13. Birthplace Va.

MOTHER 14. Maiden Name Ida B. Burgum
15. Birthplace Virginia

16 (a) Informant Mr. Robert J. Parsons
(b) Address 2406 Dorton Court-Westport

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-1-46 (month) (day) (year)

(c) Cemetery or crematory Riverview
Location Richmond, Virginia

18 (a) Funeral director W. J. Eichenlaub & Sons
(b) Address North and Penna Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 1946 at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1946, to 11-1 1946 and that I last saw h alive on 11-1 1946

Immediate cause of death Hemorrhage Cardio-respiratory failure Cerebral anoxemia — Duration

Due to Massive hemorrhage Peptic ulcer. — 5 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. O. Shallenberger Jr. M. D.
Address University Hospital Date signed 9-1-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G15153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-2
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Houser St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Queen

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Charles Queen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-17-1890

8. AGE: Years	Months	Days	If less than one day
55 52	10	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Harriett Johnson
15. Birthplace Richmond Virginia

16 (a) Informant Mrs Kate Butler
(b) Address 629 S. Paca St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11 3 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto. Md.

18 (a) Funeral director Walter R. Griggs
(b) Address 139 W. Hamburg St.

19 (a) 11/1/46 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1946, at 7.15p. M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to

Other Conditions Aortic Insufficiency Syphilis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mueller M.D.
Medical Examiner.
Date signed 10-31-46

VS 181

Dr. Lippy
432 S. Patt. Pk Ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45151

1-3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 S. Milton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 S. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William David Hoover

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marie Hoover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1901

8. AGE: Years	Months	Days	If less than one day
45	4	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter R. Hoover
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md.

16 (a) Informant Mrs. Marie Hoover
(b) Address 705 S. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore,

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Now (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30th, 1946 at 3-7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946 to Oct 30 1946, and that I last saw him alive on Oct 30 1946

Immediate cause of death
Thrombotic Pneumonia
Duration 5 yrs.
Due to
Heart trouble - years ago.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 S Eutaw St Date signed 11/5/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

B.C. 10/31/46
Dec 9. 6121 2
C45155

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Reg. No. 45155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 B Woodvale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sperry.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/31/46
8. AGE: Years | Months | Days | If less than one day: 10 hr. 18 min.
9. Birthplace Maryland Gen. Hosp. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Philip Sperry.
13. Birthplace Mountain View N.J.

MOTHER
14. Maiden Name Frances Kuhl.
15. Birthplace Moulton Md.

16 (a) Informant Mrs Frances Sperry.
(b) Address 201 B. Woodvale Rd Balto. Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Baltimore
18 (a) Funeral director Leonard J. Luck
(b) Address 532 N. Stanford Rd.
19 (a) (Date rec'd by registrar) (b) Registrar

NOV 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1946, at 1:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1946 to 10/31 1946; and that I last saw h. alive on 10/31 1946.

Immediate cause of death: Atelectasis.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Charles D. Howe M.D.
Address Maryland Gen Hosp. Date signed 10/31/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15156 D.C. 9-60954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G15159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town (Parents) Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Gorman Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Powers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wh.	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/29/46

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace University Hosp, Balto, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm Martin Powers
13. Birthplace Green Bay, Wisconsin

MOTHER
14. Maiden Name Jessie Merson
15. Birthplace Laurel, Md.

16 (a) Informant Mrs. Jessie Powers
(b) Address 413 Gorman Ave, Laurel, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

NOV 1 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1946, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23-1946, to 10-29-1946, and that I last saw her alive on 10-29-1946.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Leary M. D.

Address Date signed 10-31-46

Physicians: please write the correct age in especially important.

NOV 1 1946 University Medical School
City Commissioner of Health

G15157 P.C. G-60866

G15157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts. 18-3

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town (Md.) Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1 S. Amity St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Falcon

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-29-46

8. AGE: Years	Months	Days	If less than one day
—	—	1	26 hrs min.

9. Birthplace Balto. Md. (Univ. Hosp.)

(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Leroy Scott

13. Birthplace Not known

MOTHER

14. Maiden Name Elizabeth Falcon

15. Birthplace —, North Carolina

16 (a) Informant Elizabeth Falcon

(b) Address 1 S. Amity St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School

18 (a) Funeral director

(b) Address

(c) (Date rec'd by registrar) (d) Huntington Williams M.D.

NOV 1 1946

Commissioner of Health

NOV 1 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31- 1946, at 2:48 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1946, to 10-31 1946, and that I last saw h[illegible] alive on 10-30-1946.

Immediate cause of death

(a) Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address Date signed

G15158

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 92a

G15158

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 College Terrace
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Chaney, Ernest

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1884

8. AGE: Years	Months	Days	If less than one day
62	9	28	hr. min.

9. Birthplace St. Michael, Md.
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Seafarer

FATHER
12. Name Ennels Chaney
13. Birthplace St. Michale, Md.

MOTHER
14. Maiden Name Louise Pinkney
15. Birthplace Broad Creek, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory St. Michaels Md.
Location St. Michaels Md.

18 (a) Funeral director J. Thomas Mitchell
(b) Address St. Michaels Md.

19 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946, at 9:07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1946, to Oct. 31 1946, and that I last saw him alive on Oct. 31 1946.

Immediate cause of death Heart failure due to aortic stenosis and insufficiency — Duration UNKNOWN

Due to — Duration

Due to Arteriosclerosis — Duration UNKNOWN

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/1/46

VS 150

G15159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓55E

G15159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 873 N Ostend Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Creek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	c	married

6 (b) Name of husband or wife Charles Creek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/1878

8. AGE: Years	Months	Days	If less than one day
67	11	25	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Henson Johnson

13. Birthplace md

MOTHER 14. Maiden Name Rachel A Johnson

15. Birthplace md

16 (a) Informant Katie Adams

(b) Address 1408 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Bronze

Location

18 (a) Funeral director Elroy DeWilson

(b) Address 1000 Braddish Ave

NOV 1 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/46 19 at 1:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Carcinomatosis

Due to

Other Conditions Decubitus Ulcers

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 10/30/46

G25160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G25160 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1168 Hanticoke St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1168 Hanticoke St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin J. Cosgrove

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Standiford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9-1886

8. AGE: Years 59 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Patrick Cosgrove
13. Birthplace Ireland

MOTHER 14. Maiden Name Hetta Coghahan
15. Birthplace Ireland

16 (a) Informant Mrs Mary Cosgrove
(b) Address 1168 Hanticoke St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-1946 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

NOV 1 1946 (Death rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29- 1946, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Oct 29 1946, and that I last saw h[illegible] alive on Oct 29 1946.

Immediate cause of death
Cerebral Hemorrhage — Duration 6 weeks
Due to Arteriosclerosis — Duration 2 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2201 Druid Pk Date signed 10/29/46

VS 150

G25161 KUHLMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G25161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 297 S. Pulaski
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 297 S. Pulaski Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD B. KUHLMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-8148

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15-1883

8. AGE: Years 63 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Balto Butchers Abattoir

FATHER 12. Name Henry Walter Kuhlman

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Anna Lipner

15. Birthplace Germany

16 (a) Informant Mrs. Carl Stengel

(b) Address 297 S. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4-1946 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director George L. Schwab

(b) Address 2101 Eutaw Place Ave

19 (a) NOV 2 1946 (Date rec'd by registrar) Registrar for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/46 19 6:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner
Date signed 11/1/46

VS 151

G15162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

Registered No. G15162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene
(c) Hospital or institution:
Univ. Hosp. 21

(d) Length of stay in hospital or inst. (yrs., mos., or days) 62 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Ramsay St #30 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH SEIFERT

3 (b) If veteran, name war

3 (c) Social Security Account No. 27-16-6260

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (Mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
31	8	27	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Unemployed.
11. Industry or business Shifting Clerk

FATHER
12. Name Jacob Seiffert
13. Birthplace Pa.

MOTHER
14. Maiden Name Sadie E. Smith
15. Birthplace Md.

16 (a) Informant Jacob Seifert
(b) Address 719 Ramsey St.

17 (a) Burial (b) Date thereof 11/4/46
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Wm. Cook. Inc.
(b) Address 1217 St. Paul St.

19 Filed by Huntington Williams NOV 2 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 1946, at 5:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1946 to 11/1 1946, and that I last saw h. alive on 11/1 1946.

Immediate cause of death	Duration
Cardio respiratory failure, uremia, acidosis, diabetes mellitus, paraphrenia	5 days
Due to pulmonary tuberculosis, fibrous renal hyperparathyroidism	
Due to (a), hypertension, chronic glomerular nephritis, anasarca,	
Other Conditions pulmonary edema, convulsions, hypertensive encephalopathy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. O. Shallenberger Jr. M.D.
Address Univ. Hosp. Date signed 11/1

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

945163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 945163

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 So Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 So. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas V. Murray.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Feby 14 - 1884

8. AGE: Years 62. | Months 8 | Days 17 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, state or state)

10. Usual Occupation Bottle stopper

11. Industry or business Globe Cork Co.

FATHER 12. Name William J. Murray

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Annie E. Oakley

15. Birthplace Md.

16 (a) Informant Miss Catherine B. Murray

(b) Address 21 So Calvert St Ba

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46
(month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Shell Rd

18 (a) Funeral director Solon Conway & Son

(b) Address 901-03 Collins Ave

19 (a) (Date rec'd) NOV 2 1946 (b) Huntington Williams (Signature)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/1946 at 9:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 4/1 1946 to 11/1 1946, and that I last saw h alive on 11/1 1946.

Immediate cause of death Hypertension Duration 1 yr
Heart disease

Due to

Due to

Other Conditions Cardiac Renal
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Wells M. D.

Address 2030 Wilkens Date signed 11/4/46

C45164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

Registered C45164

Please write the causes of death clearly and legibly. Physicians: please correct age if apparently important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2769 W. North Ave.
(c) Hospital or institution:

15 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2769 W. North Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS LEFRANC

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Isabelle or Belle Lefranc
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1864

8. AGE: Years	Months	Days	If less than one day
84	4	7	hr. min.

9. Birthplace Chenon, France (Town, county, and state)
10. Usual Occupation Shirt Mgr. Retired
11. Industry or business

FATHER
12. Name Francois Lefranc
13. Birthplace France

MOTHER
14. Maiden Name Amelie Chaffiot
15. Birthplace France

16 (a) Informant Mrs. Isabelle Lefranc
(b) Address 2769 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 2 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Oct. 30 1946 and that I last saw him alive on Oct. 30 1946.

Immediate cause of death	Duration
Broncho Pneumonia	4 days.
Due to Chronic Interstial Nephritis	Not Known
Due to Arteriosclerosis	Not Known
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: — None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Wilbur A. Sinton M.D.
Address 2824 St. Paul St. Date signed 11-1-46

VS 150

G45165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. G45165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 N Fulton Ave
(c) Hospital or institution: Bon Secours Hospital

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 131 N Fulton Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Isabell Orem

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eugene W Orem
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18 1899

8. AGE: Years 46 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Wm Shotwell
13. Birthplace Penna

MOTHER 14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Eugene W Orem
(b) Address 131 N Fulton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Balto Md

18 (a) Funeral director Geo A Epley
(b) Address Fulton & Fayette

NOV 2 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/1946 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16/1946 to 10/31/1946 and that I last saw h[illegible] alive on 10/31/1946.

Immediate cause of death	Duration
Cardio Respiratory Failure	5 Minutes
Due to Cerebral Anoxia	unknown
Due to General Anaesthesia, Gas, Oxygen ether	1 Hr. 15 Minutes
Other Conditions Thyrotoxicosis, Thyrocardiac Disease (Include pregnancy within 3 months of death)	2 Years

Date of operation 10/31/46
Major findings of operation: Toxic Goitre
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur W. Lyons M. D.
Address Bon Secours Hosp Date signed 10/31/46

Howard J. Andersen, M.D. - X

please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

VS 150

G45166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45166

please write the causes of death clearly and legibly. Physicians: please see that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 N. Rolling Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Collins
3 (b) If veteran, name war
3 (c) Social Security Account No. 577-22-8070

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Esther V. Collins
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 26-1900

8. AGE: Years	Months	Days	If less than one day
46	9	5	hr. min.

9. Birthplace Baltimore Md. (Town, county, or state)
10. Usual Occupation Tool Crib attendant
11. Industry or business

FATHER
12. Name James L. Collins
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Wilhelmina Pfeiffer
15. Birthplace Balto Md

16 (a) Informant Naomi Musgrove
(b) Address Westchester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2-46 (month) (day) (year)
(c) Cemetery or crematory Mary Cathedral
Location Balto Md.

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette

19 (a) NOV 2 1946 Huntingdon Pennsylvania, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1946, at 3 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1946 to 10/31 1946 and that I last saw him alive on 10/31 1946

Immediate cause of death	Duration
Cardio-Respiratory Failure	few hours
Due to Obstructive Jaundice	3 wks
Due to Carcinoma Head of Pancreas	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinoma Head of Pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Catherine W Lyons M. D.
Address Bon Secours Hosp Date signed 11/2/46

C45167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

C45167 Registered No. 3692

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Riggs ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Riggs ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha F. Coykendall
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 25 1895

8. AGE: Years	Months	Days	If less than one day
51	6	6	hr. min.

9. Birthplace Northumberland Co. Va
(Town, county, and state)
10. Usual Occupation House work
11. Industry or business own home

FATHER
12. Name Judson Flowers
13. Birthplace Va

MOTHER
14. Maiden Name Emma Clark
15. Birthplace Va

16 (a) Informant Mary E. Saunders
(b) Address 1401 Mosher St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov 2-1946 (month) (day) (year)
(c) Cemetery or crematory Virginia Cemetery
Location Lottsburg Va

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

NOV 2 1946 Barbara Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11—1—1946 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5—1—1946 to 11—1—1946 and that I last saw him alive on 10—31—1946.

Immediate cause of death	Duration
Chronic arthritis	Unknown
Due to	
Due to	
Other Conditions Malnutrition	Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 11-2-46

VS 180

X

C45168 BALTIMORE CITY HEALTH DEPARTMENT C45168

CERTIFICATE OF DEATH

Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 8th St. Sps.Pt. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Snavely

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-6992

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Angelina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1902

8. AGE: Years 44 | Months 3 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Johnstown Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Nevin Snavely
13. Birthplace Johnstown Pa

MOTHER 14. Maiden Name Gertrude Stevens
15. Birthplace Johnstown Pa.

16 (a) Informant Phyllis Snavely
(b) Address 1102 - 8th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4/46 (month) (day) (year)

(c) Cemetery or crematory
Location Johnstown Pa.

18 (a) Funeral director John J. McGann
(b) Address 3000 E. Baltimore St.

19 (a) NOV 3 1946 (Date rec'd by Reg.) (b) Huntington Williams, Jr. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946, at 7.15 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured pelvis
Intra-abdominal hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-46 2 p. M.
(b) Where did injury occur? 600 block Nth. Pt. Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hit by auto

23. Signature George R. Merrill M.D. Medical Examiner.
Date signed 11-1-46

G45169 RUSSO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G45169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 South [redacted] Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Kirkley Russo

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Frank B. Russo
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 29, 1879
8. AGE: Years 66 Months 11 Days 3 If less than one day hr. min.
9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Edward Thomas
13. Birthplace Balto

MOTHER
14. Maiden Name Joana Reese
15. Birthplace Balto

16 (a) Informant Frank B. Russo
(b) Address 2314 W. Garrison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Bel Air Road
18 (a) Funeral director John O. Mitchell Sons
(b) Address 1925 Eastern Place
19 (a) (Signature of registrar) (b) Huntington Williams M.D. Registrar

NOV 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1946, at 4 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1946, to Nov 1 1946, and that I last saw h[illegible] alive on November 1946.

Immediate cause of death Cardio-respiratory paralysis; uremia; hydronephrosis & hydroureteronephrosis, bilateral; Due to or as a consequence of Bladder tumor (papillary carcinoma)

Other Conditions Hydroureteronephrosis, bilateral; pulmonary congestion, bilateral; edema, legs; hemoptysis, bilateral; atelectasis, left

(Include pregnancy within 3 months of death)

Duration

Date of operation Tumor biopsy, cystoscopic

Major findings of operation: hypertrophy, transurethral resection

of autopsy: Hypertrophy of prostate gland, bladder tumor

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry E. Kirkley M.D.
Address Union Hosp. Date signed 11/4/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Spence

G45170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St
(c) Hospital or institution: Home for Incurables 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Davis Spence

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Albertine Spence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 - 1886

8. AGE: Years	Months	Days	If less than one day
60	5	26	hr. min.

9. Birthplace Rural Retreat, Virginia
(Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Charles Spence
13. Birthplace Rural - Retreat - Virginia

MOTHER
14. Maiden Name Maretta Davis
15. Birthplace Rural - Retreat - Virginia

16 (a) Informant Emily Bachtel Rue
(b) Address Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) NOV 2 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1946, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1945 to 11/1 1946, and that I last saw him alive on 10/31 1946.

Immediate cause of death: Uremia - Interstitial Nephritis (Medical) due to Bronchogenic Carcinoma (Surgical) — 4 Months

Due to: Cancer of upper abdominal point + Lower Lung — 2 Months

Due to: Hypertension Cardio Vascular Disease — 3 years

Other Conditions: Right Hemiplegia — 2½ years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hergesheimer M.D.
Address 214 Medical Arts Bldg. Date signed 11/7/46

123

Correct Age if especially important. Prepare plainly with ink and write the causes of death clearly and legibly.

G45171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G45171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Belmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE SCHWESSINGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Matilda Schwessinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1882

8. AGE: Years	Months	Days	If less than one day
64	6	19	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Field Representative
11. Industry or business New Amsterdam Casualty Co.

FATHER
12. Name -
13. Birthplace

MOTHER
14. Maiden Name Mary Elizabeth Appel
15. Birthplace

16 (a) Informant Mrs. Matilda Schwessinger
(b) Address 3201 Belmont Ave.

17 (a) Burial (b) Date thereof 11/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 2 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. No. 1, 1946, at 12:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1946 to Nov 1 1946 and that I last saw alive on Oct 31 1946

Immediate cause of death: Chronic Cardio Vascular disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest H. Cahn

Address 1735 Pgh Bk Bldg Date signed 11/1/46 M D

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45172 Black 11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G45172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves.
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Allendale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M. Black

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1880

8. AGE: Years 66 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Harrington
15. Birthplace Maryland

16 (a) Informant Mr. Thomas Black
(b) Address 2202 Allendale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) NOV 2 1946 (Date filed) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1946, to 11/1 1946, and that I last saw her alive on 11/1 1946.

Immediate cause of death: Respiratory Failure — Duration

Due to Ovarian Malignancy
Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley Myaffe, M.D.
Address Sinai Hosp. Date signed 11/1/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. G45173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7314 OLD HARFORD RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7314 OLD HARFORD RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA C. MILLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife: JOSEPH W. MILLER

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) FEB 28 1898

8. AGE: Years 48 Months 8 Days 3 If less than one day hr. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER | PARENTS
12. Name GEORGE BORNSCHLEGEL
13. Birthplace BALTO MD

MOTHER | PARENTS
14. Maiden Name LENA HIPCHEN
15. Birthplace GERMANY

16 (a) Informant: JOS. W. MILLER
(b) Address 7314 OLD HARFORD RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 4-46 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A.A.Co.

18 (a) Funeral director Bernard E. Hasle
(b) Address 121 E. West St

NOV 2 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 31 1946 at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10/42 19 to 10/31/ 1946, and that I last saw her alive on 10/31/ 1946.

Immediate cause of death: Chronic myocarditis — Duration 3 yrs.

Due to Hypertrophic (chronic) arthritis. — 5 yrs.

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 11/1/ 1946.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G45174 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 Harlem
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgiana Bellfield

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife John Bellfield 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1891

8. AGE: Years	Months	Days	If less than one day
55	4	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Benjamin V. Green
13. Birthplace Charles Co. Va.

MOTHER 14. Maiden Name Lucinda Tunstall
15. Birthplace Essex Co. Va.

16 (a) Informant Edna B. Cook
(b) Address 1802 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (day) (year) Nov 2 1946
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 225 N. Schroeder St

NOV 2 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1946 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946 Oct. 30 1946 and that I last saw h[illegible] alive on Oct. 29 1946

Immediate cause of death
Chronic Valvular Heart Disease

Duration
6 Months

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Lincoln Hatton M.D.
Address 1858 Harlem Ave. Date signed 10/31/46

VS 150

G45175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 N° Gilmor St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Dft

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 N° Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ARIA JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Henry Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1889

8. AGE: Years 57 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Thompson, Ga. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown.
13. Birthplace

MOTHER
14. Maiden Name Hettie Cobb.
15. Birthplace

16 (a) Informant Benjamin Jones
(b) Address 1506 Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co., Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill ave. Huntington Williams, Mgr.

NOV 2 1946 (Date rec'd by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/46 19.., at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..., M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John D. Evans M.D. Medical Examiner.
Date signed 11/1/46

X

G45176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 172

Registered No. G45176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Key Highway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Neville B. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Allie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Laval Late W. Va. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business Ship yard

FATHER
12. Name Carneal
13. Birthplace W. Va.

MOTHER
14. Maiden Name Sarah
15. Birthplace W. Va.

16 (a) Informant Silvia Moser
(b) Address 731 Reservoir St.

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 11/2/46 (month) (day) (year)
(c) Cemetery or crematory Parks mortuary Ohio
Location

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) (b) Date rec'd by Registrar NOV 2 1946 Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1946, at 11 A.M. 50

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed head, Fractured ribs

Due to

Other Conditions Other fractures and bruis burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-1-46 at 11:35 A.M.
(b) Where did injury occur? (Drawing dock) 1101 Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury fell to dock when life let go

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11-2-46

24/2

X

Tr. No. 103293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45177 ✓ 18½a Registered No. G45177

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Jackson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Madgelene Campbell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Peter (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1866

8. AGE: Years	Months	Days	If less than one day
80	1	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Casper Dull
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Joyce
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory CATHEDERAL CEM.
Location FREDERICK AVE

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St
NOV 2 1946 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946; at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1946 to Oct. 31 1946 and that I last saw her alive on Oct. 31 1946.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease, c Congestive failure	
Due to	
Due to	
Other Conditions Subtrochanteric fracture - rt. - Pinned (Include pregnancy within 3 months of death)	

Date of operation 10-1-46
Major findings of operation: Above
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 29, 1946 at — M
(c) Where did injury occur? 1413 Jackson St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Slipped, fell & flew

23. Signature Marshall M. Lacy, M.D. M. D.
Address Baltimore City Hospitals. Date signed 10-31-46

VS 150

To be approved by Medical Examiner
For S.S.R. Davis, Howard [illegible], M.D. X

G45178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 C

Registered No. G45178

1. PLACE OF DEATH;
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond E. Foster

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1938

8. AGE: Years	Months	Days	If less than one day
8	9	10	hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Clarence W. Foster
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lucie Eggenrieth
15. Birthplace Kansas

16 (a) Informant Clarence W. Foster
(b) Address 2218 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3 1946 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St Pauls
Location Violetville

18 (a) Funeral director Harry A Wotyla Edmondson
(b) Address 4696

19 NOV 2 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1946 at 6.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Ruptured liver
Hemoperitoneum
Due to Multiple fractures

Other Conditions Lacerations, bruised brain abrasion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-30-46 5 p. M. (Eastern Std.)
(b) Where did injury occur? Francis & 2nd ave. Halethorpe.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Pediastrian -hit by auto

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-31-46

VS 191

G45179

503543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G45179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 W Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) FULL NAME Ella R. McDowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-65

8. AGE: Years 80 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?, Hyle
13. Birthplace ?, Md.

MOTHER
14. Maiden Name ?, ?
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mar. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Mausoleum Lorraine Park
Location

18 (a) Funeral director Henry H Wetzler
(b) Address 4101 Edmondson Ave

19 (a) NOV 2 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1946 at 1. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1946, to Nov 1 1946 and that I last saw him alive on Nov 1 1946.

Immediate cause of death	Duration
Myocardial Infarction	
Due to Coronary Thrombosis	
Due to Hypertensive Arteriosclerotic Heart disease	
Other Conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy: Confirmed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. S. Speed, MD
Address Johns Hopkins Hosp. Date signed 11/1/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

937

G35180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

Registered No. G35180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 E. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H. Johannes Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose Lee —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-1888

8. AGE: Years 58 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER

12. Name H. H. Johannes

13. Birthplace Maryland

14. Maiden Name Hilda A. Harbine

15. Birthplace Hurdon

16 (a) Informant Mrs. Hilda A. Johannes

(b) Address 213 S. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-Nov-36 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director C. D. Thibert & Son

(b) Address 300 Eutaw Place

19 (a) Date rec'd by local reg. NOV 2 1936 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/36 19 1:40a M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1 1936 to Oct 30 1936 and that I last saw h[e] alive on Oct 30 1936.

Immediate cause of death: Acute Myocarditis

Due to Paralysis Respiratory — Duration 3 weeks

Due to Asthenia Anaemia — 2 months

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen A. Loker

Address 300 Eutaw Place Date signed 11/1/36 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

345181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

Registered No. G45181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOA
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Warren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace A. G. Co Md
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Thomas Warren
13. Birthplace A. G. Co Md

MOTHER
14. Maiden Name Margt Queen
15. Birthplace A. G. Co Md

16 (a) Informant Leroy Nicholson
(b) Address Brooklyn Md R.F.D

17 (a) Burial (b) Date thereof Nov. 3. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 NOV 2 1946 Huntington Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/ 1946 at 8 31 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of rectum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubrick M.D.
Medical Examiner.
Date signed 11/1/46

G45183

279064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. G45182

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 / 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1786 Bonner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-7-99

8. AGE: Years	Months	Days	If less than one day
47	2	22	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Parking House Man

11. Industry or business

FATHER
12. Name Vincent Butler
13. Birthplace Virginia

MOTHER
14. Maiden Name Gabrielle Johnson
15. Birthplace Virginia

16 (a) Informant Nurse
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 2 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brightwood Ave

NOV 2 1946 (a) (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1946, at 1 45 P. M

21. I certify that death occurred on the date above stated: that I attended deceased from 10-20 1946, to 10-29 1946, and that I last saw h alive on 10-29 1946.

Immediate cause of death Questionable Probable bronchopneumonia bilateral

Duration 10 days?

Due to

Due to

Other Conditions Carcinoma moderately far to perforation of ulcer Hemicolectomy

(Include pregnancy within 3 months of death)

Date of operation 10-22-46

Major findings of operation: Wide ca ascending colon

of autopsy: bilateral pneumonia

?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Bruce J. Tracy M. D.
Address The Johns Hopkins Hosp Date signed 10-31-46

VS 150

45183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. 45183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1043 Chapel st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 Chapel st (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country N. Chapel St.

3 (a) FULL NAME Hilda Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Wm. Spencer Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1927

8. AGE: Years 19 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Same

FATHER
12. Name Lucian Harris
13. Birthplace Shepardstown, W. Va.

MOTHER
14. Maiden Name Viola Curry
15. Birthplace Lancaster Co., Va.

16 (a) Informant Viola Harris
(b) Address 1043 Chapel St

17 (a) Burial (b) Date thereof 11/3/46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director Geo. L. Kelson
(b) Address 1303 Pennsylvania Ave

19 NOV 2 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946 at 3.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26-1946 to 10-31-1946 and that I last saw her alive on 10-31-1946.

Immediate cause of death Pulmonary tuberculosis — Duration 6 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. T. Compher M. D.
Address 634 N. Carey St Date signed 11-2-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

G45184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saint Joseph.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Sumter Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elora Margaret Marsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward L. Marsh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1901

8. AGE: Years 45 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

MOTHER | FATHER

12. Name William M. Weedon

13. Birthplace A.A. County, Md.

14. Maiden Name Mattie V. Woodward

15. Birthplace Phila. Pa.

16 (a) Informant Mrs. Edward L. Marsh

(b) Address 3116 Sumter Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights.

NOV 3 1946 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1946 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 17 1946 to November 4, 1946, and that I last saw he alive on November 4, 1946.

Immediate cause of death	Duration
Cardiac Respiratory failure	
Due to Generalized Carcinomatosis	
Due to Undifferentiated Carcinoma of left Breast (Removed 2 years ago)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Linehan M.D.

Address Sinai Hospital Date signed 11/1/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 96

G45185

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town West Palm Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Kanawha Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma L. Reeder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Alf Reeder
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 2-13-05

8. AGE: Years	Months	Days	If less than one day
41	8	19	hr. min.

9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Newell T. Gray
13. Birthplace Tennessee

MOTHER
14. Maiden Name Minnie Brewer
15. Birthplace Tennessee

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location West Palm Beach Fla
18 (a) Funeral director John C. Fuller Sons
(b) Address 245 E. Oliver St
19 (a) (Date rec'd) NOV 5 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1946, at 6 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1946 to 11-2 1946, and that I last saw h[illegible] alive on 11-2 1946.

Immediate cause of death: Subarachnoid Hemorrhage — Duration 1/2 hr.
Due to Cerebral Aneurysm
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation —
of autopsy Cerebral Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Arthur M. Craig
Address Johns Hopkins Hosp Date signed 11/3/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45186 Registered No. 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Florida (b) County
(c) City or town Jacksonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Naval Air Gunnery Range Box 76
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pamela Kitterman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28, 1946

8. AGE: Years | Months | Days 4 days | If less than one day hr. min.

9. Birthplace Jacksonville Florida
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Kitterman
13. Birthplace Pittsfield, Mass.

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Roy K. Hoffman
(b) Address 44 Checkering St., Pittsfield, Mass.

17 (a) Cremation (b) Date thereof 11/2/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Pittsfield, Mass.

18 (a) Funeral director M. W. E. Appel & Sons
(b) Address Homeland - Ann St.

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williamsburg, Mass

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1946, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1946 to Nov 1 1946, and that I last saw h alive on Nov 1 1946

Immediate cause of death: Laceration of Aorta

Due to Lacerations of Liver

Due to

Other Conditions Ruptured Cardio Esophageal

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Levine
Address Redwood & Greene Date signed 11/5/46

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS 150

G45187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45187 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 S. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County Volusia
(c) City or town Seville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William David Rauleson

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary R. Rauleson

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) February 11, 1867

8. AGE: Years 79 | Months 8 | Days 21 | If less than one day ___ hr. ___ min.

9. Birthplace Seville, Volusia County, Florida (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Retired

FATHER
12. Name Robert R. Rauleson
13. Birthplace [redacted] Georgia

MOTHER
14. Maiden Name Barbara Bradshaw
15. Birthplace North Carolina

16 (a) Informant Martha R. Brown
(b) Address 16 S. Carey Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-46 (month) (day) (year)
(c) Cemetery or crematory Seville
Location Seville, Florida

18 (a) Funeral director George L. Schwab
(b) Address 2109 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st 1946 at 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Aug. Ed. Chup. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular disease;

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ___ at ___ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Hoffeck M.D.
Medical Examiner.
Date signed 2 Nov 46

G45188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45188 Registered No. 1334

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 1/2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3429 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Louis Lessner
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Russia

16 (a) Informant William Shapiro B
(b) Address 3429 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3. 1946 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew Cemetery
Location Belair Road

18 (a) Funeral director Spl Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 3 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946, at 10.40 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Peritonitis
Right pyonephrosis
Generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-24-46 Dat M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 11-1-46

G45189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G45189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 923 Whitelock St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Whitelock St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE RAPPAPORT

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife late Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	16	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Aaron Stutman
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Ehrlichman
15. Birthplace Russia

16 (a) Informant Mrs. Ray Cminsky
(b) Address 923 Whitelock St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

NOV 3 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1946, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1946 to Nov 1 1946, and that I last saw h[illegible] alive on Oct 29 1946

Immediate cause of death Coronary Thrombosis — Duration

Due to Arterio-Sclerosis

Due to Diabetes.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: not Done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter H. Kalman M.D. M. D.
Address 3700 Park Heights Ave Date signed Nov 2 1946

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45190

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Beechdale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Beechdale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUSSELL B. MARCHANT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elvira Doer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1871

8. AGE: Years	Months	Days	If less than one day
75	4	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER: 12. Name Alexander Marchant
13. Birthplace Virginia

MOTHER: 14. Maiden Name Susan Forrest
15. Birthplace Virginia

16 (a) Informant Mrs Howard L. Martenet
(b) Address 110 Beechdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Christ Church Cem.
Location Mathews, Va.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

NOV 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1st 1946, at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946, to Nov 1946, and that I last saw h[illegible] alive on Nov 1st 1946.

Immediate cause of death: Acute Pulmonary Edema — Duration

Due to

Due to Atherosclerotic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William G. Hedrich M. D.
Address 5006 Roland Ave Date signed Nov 4 1946

G45191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45191 / 107 — Registered No. G45191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Ridgely Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Florence Hilton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1868

8. AGE: Years	Months	Days	If less than one day
78	-	29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Boshamer
13. Birthplace Germany

MOTHER
14. Maiden Name Hankward
15. Birthplace Ireland

16 (a) Informant Mrs. Carroll Neser
(b) Address 236 Mallow Hill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Baltimore Md

18 (a) Funeral director Maurice Book Sayer
(b) Address 1600 E. North Ave

19 (a) Date received NOV 5 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1946, at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1946 to 10-31 1946, and that I last saw h er alive on 10-31 1946

Immediate cause of death: Cardiac Failure — Duration

Due to Acute cardiac dilatation

Due to Bronchopneumonia

Other Conditions Rheumatoid arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wat Hollis M. D.
Address St. Agnes Hospital Date signed 10-31-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

Give the cause of death clearly and legibly. Physicians: please write the exact age is especially important.

VS 150

Dr. G55132
3001 Shannon Drive

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a G55108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address S.
(c) Hospital or institution:
PINE RIDGE Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County Fullerton
(c) City or town Baltimore Fullerton (If outside city or town limits, write RURAL and give town)
(d) Street No. S. Baker & Putty Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Preller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife George C. Preller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Bittner
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Wentzel
15. Birthplace Md.

16 (a) Informant Mrs. George C. Preller
(b) Address S. Baker & Putty Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Herford Road

19 (Date received by registrar) NOV 3 1946 Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to Nov 1 1946 and that I last saw h[illegible] alive on Oct 31 1946.

Immediate cause of death	Duration
Pneumonia (Terminal)	
Due to Cerebral Embolus	
Due to	
Other Conditions Arteriosclerosis Fractured left Hip — Aug 3-46 (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 27/2
(b) Date of occurrence Aug 3, 1946 at M
(c) Where did injury occur? Pinerridge Nursing Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Building While at work? No (Specify type of place)
(e) Means of injury Tripped fell to floor
23. Signature Marie A. Stetson M. D.
Address 3001 Shannon Rd Date signed NOV. 2 46

VS 150

corrected J. Mueller, M.D. NOV. 2-46

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause

G45193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G45193
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital. Balto, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Juniper Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vesta C. Aycock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Thomas B.

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Aug. 11-1903

8. AGE: Years	Months	Days	If less than one day
43	2	22	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Thomas McGuire
13. Birthplace Pa. or Va.

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Thomas B. Aycock.
(b) Address 3810 Juniper Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-46 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park. Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 1946 to Nov 2 1946 and that I last saw h.E.R. alive on Nov 2, 1946.

Immediate cause of death: Cerebral compression & Cerebral hemorrhage — Duration: 12 hours 12 hours

Due to: Fall down stairs

Due to:

Other Conditions: Malnutrition

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov 1, 1946 at 6 P.M.
(c) Where did injury occur? Baltimore (City or town) (County) Maryland (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall down stairs

23. Signature Edward F. Potts

Address 11 E. Chase St. Date signed Nov 4 1946

Howard J. Wondrisch, M.D. X

G45194 BALTIMORE CITY HEALTH DEPARTMENT G45194
Registered No.

CERTIFICATE OF DEATH V137a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 Forest St.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace, Frank

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-07-3222

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Married

6 (b) Name of husband or wife Gertrude Hartley
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	21	hr. min.

9. Birthplace Portugal
(Town, county, and state)
10. Usual Occupation AB seaman
11. Industry or business Seafarer

FATHER
12. Name John Grace
13. Birthplace Portugal

MOTHER
14. Maiden Name Isabelle ?
15. Birthplace Portugal

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Nov 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt calvary
Location O. A. C. Md

18 (a) Funeral director Bryon Marvin H. Wright
(b) Address 721 Pisgah Ave Baltimore Md

19 (a) [illegible] by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1946 to Oct. 31 1946 and that I last saw him alive on Oct. 31 1946.

Immediate cause of death Acute congestive heart failure occuring during transurethral Resection of prostate under spinal novocaine and intravenous

Due to Sodium pentothal anesthesia

Other Conditions Hypertrophy of the Prostate Benign

(Include pregnancy within 3 months of death)

Date of operation 10-31-46

Major findings of operation: Hypertrophy of Prostate

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John L. Williams
Address U.S. Marine Hospital Date signed 11/31/46 M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45195 BALTIMORE CITY HEALTH DEPARTMENT G45195

CERTIFICATE OF DEATH

Registered No. 1270

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Havre De Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3. (a) FULL NAME Bessie Tucker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife W. C. Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1904

8. AGE: Years	Months	Days	If less than one day
42	9	10	hr. min.

9. Birthplace Fox, Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alex Donovan
13. Birthplace Virginia

MOTHER
14. Maiden Name Leona Nash
15. Birthplace Virginia

16 (a) Informant W. C. Tucker
(b) Address Havre De Grace, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cem.
Location Harford Co. Md.

18 (a) Funeral director W. Madison Mitchell
(b) Address Havre de Grace Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3rd 1946, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1946 to Nov 3 1946 and that I last saw her alive on 3 Nov. 1946.

Immediate cause of death	Duration
Acute Pulmonary Oedema	5 hrs.
Due to Pulmonary embolus	5 hrs.
Due to	
Other Conditions Chronic Cholecystitis	12 yrs.

(Include pregnancy within 3 months of death)
Date of operation Nov. 1946
Major findings of operation Chr. Cholecystitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas M. Hurlstone M. D.
Address South Balto. Hosp. Date signed 3 Nov. 1946

VS 150

AB- 100 G45196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

[redacted] G45196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 & 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1057 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Howard (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12- 1886

8. AGE: Years	Months	Days	If less than one day
60 ?	9	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Rossman (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Welton (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-4-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral MT. OLIVET
Location Baltimore Md.
18 (a) Funeral director Flynn & Fleming
(b) Address 416 Light St.

(a) (b)
(Date rec'd by registrar) Registrar

NOV 5 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31- 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29 1946 to 10-31 1946, and that I last saw her alive on 10-31 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration 4 yrs

Due to

Due to

Other Conditions Tbc. Peritonitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ad Hartz
Address Balto City Hosp. Date signed 11/5/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

G25197

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 E. Chas St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 E. Chas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry D. Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-03-2770

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife (nee Long) Caroline M. Johnson 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 18, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	13	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business U.S. Industrial Chem. Co.

FATHER
12. Name Andrew Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Martha (?)
15. Birthplace Md.

16 (a) Informant Mrs. Emrich C. Matusky, Jr.
(b) Address 23 S Chas St, Balto 39 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 1946 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Baltimore, Md.

18 (a) Funeral director C. Leonard Evans
(b) Address 400 S Charles St, Balto 39 Md

19 (a) (Date received by City registrar) (b) Registrar

Nov 5 1946 Lexington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1946, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Nov 1 1946 and that I last saw h. alive on Oct 31 1946

Immediate cause of death

	Duration
Cerebral Hemorrhage	4 hrs
Due to Arterio sclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 22 E Chas St Date signed

VS 150

X 11/2/46

G45198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45198 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 Light Dist. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Light St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Annie Woods

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1871

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Stock

11. Industry or business

FATHER 12. Name

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace " (FOWLER)

16 (a) Informant Mrs. Frances Fowler

(b) Address 1705 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Baltimore Highway

18 (a) Funeral director Peter Dow

(b) Address 1705 Light St

NOV 3 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1946, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Ht disease

Due to Frac, rt leg, rt tetra + embolism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 2315

(a) Date of injury 10/4/46 at 3:45 P.M.

(b) Where did injury occur? Hanover & Pratt

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial (While at work?) No

(d) Means of injury stumbled on street

23. Signature H. H. Williams M.D. Medical Examiner.

Date signed 11/3/46

VS 151

G45199 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 1312 — G45199 Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cathedral & Madison Sts. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas O. Lynch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1870

8. AGE: Years 76 | Months 6 | Days 15 | If less than one day: hr. 17 min.

9. Birthplace Maryland (Town, county, and State)

10. Usual Occupation police officer

11. Industry or business

FATHER — 12. Name Edward Lynch — 13. Birthplace Maryland

MOTHER — 14. Maiden Name Margaret Diffendall — 15. Birthplace Maryland

16 (a) Informant Mrs. Margaret Green
(b) Address 916 E. 33rd St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 4 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry N Wright
(b) Address 4101 Edmondson Ave

19 (a) (Date received) NOV 5 1946 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946 at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 19 46 to Oct 31 19 46, and that I last saw h[illegible] alive on Oct. 31, 19 46.

Immediate cause of death: Coma - resp failure — Duration: 9 days

Due to: Cerebral hemorrhage

Due to: Arteria - Sclerotic C-V

Other Conditions: Chronic fibroid tuberculosis Lung, Renal Failure
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas R Green M.D.
Address Mercy Hospital Date signed 11/5/46

937

200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Maryland Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Luisi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Naples, Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dominic Luisi
13. Birthplace Italy

MOTHER
14. Maiden Name Theresa, Tomacci
15. Birthplace Italy

16 (a) Informant Layng-Tinney Funeral Home
(b) Address Redwood City Cal.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/3/46 (month) (day) (year)
(c) Cemetery or crematory Redwood City Cal.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) NOV 4 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1946, at 10 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary disease
Acute congestion cardiac failure
Due to Edema and congestion of lungs
Due to Edema of brain
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercein M.D.
Medical Examiner.
Date signed 10/28/46

G45201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 51B

G45201 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County Cook
(c) City or town Chicago (If outside city or town limits, write RURAL and give town)
(d) Street No. 6146 N. Washtenaw (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Morey Kotzin

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1928

8. AGE: Years	Months	Days	If less than one day
18	1	1817	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Adolph A. Kotzin
13. Birthplace Poland

MOTHER
14. Maiden Name Elizabeth Lewartowisc
15. Birthplace Poland

16 (a) Informant: Father
(b) Address 6146 N. Washtenaw St. Chicago

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 3 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago, Ill.

18 (a) Funeral director William J. Eckner & Sons
(b) Address North & Pennsylvania Aves.
NOV 4 1946 (Date rec'd by local reg.) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946 at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1946 to Nov 3 1946, and that I last saw him alive on Nov. 3 1946

Immediate cause of death	Duration
Carcinoma of prostate gland with generalized carcinomatosis	7 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 10/31/46

VS 150

X

G45202 BCH G55011 G45202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital City
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Evesham Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas C. Port

3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1946

8. AGE: Years | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William C. Port
13. Birthplace Cleveland Ohio

MOTHER
14. Maiden Name Margot S. Anderson
15. Birthplace New York N.Y.

16 (a) Informant Margot S. Anderson
(b) Address 407 Evesham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (d) NOV 4 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1946. at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/ 1946. to 11-3-46 19 . and that I last saw him alive on Nov 3rd 1946.

Immediate cause of death Peritonitis
Duration
Due to Perforation of Sigmoid
Due to Obstruction due to
Bacterial origin

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Perforation lower 1/3 of sigmoid with peritonitis
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Wells M.D.
Address St Joseph Hosp Date signed 11-3-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 to 402 W 41st St
(c) Hospital or institution:
Home for Incurables -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr: 7mos
(e) Length of stay in Baltimore (yrs., mos., or days) life -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Balto - md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 W 40th St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret MacLeary

3 (b) If veteran, name war — No
3 (c) Social Security Account No. — None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S -

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 - 23 - 1866

8. AGE: Years	Months	Days	If less than one day
79	11	22	— hr. — min.

9. Birthplace Md -
(Town, county, and state)
10. Usual Occupation
11. Industry or business -

FATHER
12. Name David mac Leary
13. Birthplace Ireland -

MOTHER
14. Maiden Name Ann Elizabeth McNeally
15. Birthplace Balto -

16 (a) Informant Home for Incurables
(b) Address Reservoir -

17 (a) Burial (b) Date thereof 11/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 NOV 4 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1946, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1945 to Nov. 1st 1946, and that I last saw h[er] alive on Nov. 1st 1946.

Immediate cause of death: Coronary Thrombosis — Duration 3 days
Due to Hypertensive Cardio-Vascular Disease — 3 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Comas M.D.
Address 11 E. Chase St. Date signed 11/1/46
Baltimore Md.

5204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

G45204
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1901 Edgewood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Edgewood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Aldridge

3 (b) If veteran, name war: —
3 (c) Social Security Account No. 212-07-9911

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Grace Tyler Aldridge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 29 1883

8. AGE: Years	Months	Days	If less than one day
63	7	2	hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Retired
11. Industry or business Bartlett Hayward Co.

FATHER
12. Name Albert Aldridge
13. Birthplace Unknown

MOTHER
14. Maiden Name Ida M. Zimmerman
15. Birthplace Balto. Md.

16 (a) Informant J. Bartlett Aldridge
(b) Address 205 E. Tyrone Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st
19 (a) Date rec'd by registrar (b) Registered number

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1946, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1946 to 10/31 1946 and that I last saw him alive on 10/31 1946

Immediate cause of death: Coronary occlusion — Duration: 6 hrs.?
Due to: Pulmonary edema — 4 hrs.?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter
Address 3408 Windsor Ave Date signed 11/5/46

due X

5205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G45205 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1906 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Hucht

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Bernard A. Hucht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2nd 1883

8. AGE: Years	Months	Days	If less than one day
63	0	29	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Niehaus
13. Birthplace Germany

MOTHER
14. Maiden Name Frances Bothorn
15. Birthplace Germany

16 (a) Informant Bernard A. Hucht
(b) Address 1906 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co., Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

NOV 4 1946 (Date rec'd by registrar) (b) Washington William Bldg

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31st 1946, at 11 15 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1946, to Oct 31 1946, and that I last saw her alive on Oct 30 1946.

Immediate cause of death	Duration
Coronal Accident	1 hr.
Due to Hypertension	8 yr.
Due to Arteriosclerosis	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thos. Morton Jr.
Address 1932 W. Balto. St Date signed 11/1/46 M. D.

VS 150

X

5206

401847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82

G45206
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 Arabia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Alfred E. Cormack.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ada Cormack
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 9-16-80

8. AGE: Years	Months	Days	If less than one day
61	1	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Captain Police Dept
11. Industry or business

FATHER
12. Name Alfred Cormack
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Margaret O'Donnell
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul St

NOV 4 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1946, at 3 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17- 1946, to 11-3- 1946, and that I last saw h. alive on 11-3- 1946.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Cerebro-Vascular accident	15 days
Due to anesthesia ?.	
Other Conditions Arteriosclerosis generalized; uraemia	

(Include pregnancy within three months of death)

Date of operation Oct 17 1946
Major findings of operation Ruptured. Cerebral intervertebral disc
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur M. Lang M. D.
Address Johns Hopkins Hosp Date signed 11/3/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45207

AB-65797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 938

G45207
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 5 & 25 26-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Maryland House Correction (If rural, give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Joseph Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Sarah (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?- 1890?

8. AGE: Years	Months	Days	If less than one day
56?	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Jackson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Smith (D
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director George G. Nelson
(b) Address 1363 Presstman St.
NOV 4 1946 Huntington Williams Mort (Date rec'd by local registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5- 6- 1941 to 10-31 1946 and that I last saw him alive on 10-31 1946

Immediate cause of death Bronchopneumonia — Duration 1 wk

Due to

Due to

Other Conditions Hypertensive Cardiovascular disease — yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J C Robinson Jr M. D.
Address Balt. City Hosp Date signed 11/2/46

VS 150

Copies to be typewritten. Physicians please write the causes of death clearly and legibly.

G45208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registration No. G45208

Please write the causes of death clearly and legibly. Physician: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Newman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Walter Newman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1861

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	2	14	18 81	

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas H. Thompson
13. Birthplace Va

MOTHER
14. Maiden Name Thompson
15. Birthplace Va.

16 (a) Informant William Newman
(b) Address 1626 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1203 Preastman St

NOV 4 1946 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1946, at 1:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 19XX to Nov 1 19XX, and that I last saw her alive on Nov 1 1946.

Immediate cause of death Cardio Vascular Renal Disease — Duration 2 yrs.
Due to Hypertension — 2 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. William Frey M. D.
Address 1928 Penna Ave Date signed Nov 2, 1946

VS 150

5209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45209 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Locowicz or LACKOWICZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name not know
13. Birthplace Russian

MOTHER
14. Maiden Name not know
15. Birthplace Russian

16 (a) Informant Harris Ambrosik
(b) Address 1623 Lancaster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run, Balto. County

18 (a) Funeral director John J. Grefrancke Jr.
(b) Address 423 S. Paca St.

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946 at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home or farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/2/46

VS 181

G45210

BALTIMORE CITY HEALTH DEPARTMENT 168 G45210

CERTIFICATE OF DEATH

Registered No. 1700 Thames St.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Balto. Md.
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Manuel Balbero BALBERO

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years	Months	Days	If less than one day
about 45			hr. min.

9. Birthplace Spain
(Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Manuel Sanches
(b) Address 800 S. Rappolo St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart.
Location Balto. Co.
18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave
19 (a) (b) Huntingtown, Md.

Filed NOV 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946, at 5.15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Suffocation (Asphyxiation)
Due to Carbon monoxide
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31/46 4.20 a.m.
(b) Where did injury occur? 1700 Thames St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Explosion followed by fire.
23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-31-46

P.C. 9-61201

G45211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1572a

Registered G45211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Loudon
(c) Hospital or institution Md. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 4107 Burdick Ham 24.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pikesville # 8
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roby Bg Farrow

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 [illegible]

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Balto. Md
(Town, county and state)

10. Usual Occupation Minister

11. Industry or business —

FATHER
12. Name Charles Virgil Farrow
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Margorie May Parent
15. Birthplace Balto. Md

16 (a) Informant Martin Farrow
(b) Address 4107 Burlington Rd.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey Sons
(b) Address 1827 N. North Ave.

19 (a) (Date received by registrar) NOV 4 1946 (Signature of registrar) Huntington Pottenger, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3-46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28-46 19 , to 11-3-46 19 , and that I last saw him alive on 11-3-46 .

Immediate cause of death: Intracranial hemorrhage — Duration

Due to Hydrocephalus

Due to Spina Bifida

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lorna C. Webster M. D.
Address Md. Gen. Hosp. Date signed 11-5-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G45212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

Registered No. G45212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2258 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Toba Hinda Yoffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1856

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Dalid
13. Birthplace Russia

MOTHER
14. Maiden Name Shanie Bailey
15. Birthplace Russia

16 (a) Informant Benjamin Yoffe
(b) Address 3825 Monticello ave

17 (a) Burial (b) Date thereof November 4, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

NOV 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1946, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946, to Nov 3 1946 and that I last saw her alive on Oct 25 1946.

Immediate cause of death	Duration
Coronary Thrombosis	Suddenly
Due to arteriosclerosis. Renal decay.	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Friedman M. D.
Address 1206 E. Preston Date signed Nov 4 1946

G45213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

G45213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S. Patterson Park (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas J. Prevas

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Nicholas J. Prevas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 15, 1920

8. AGE: Years: 26 Months: 5 Days: 17 If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: U.S. Army
11. Industry or business

FATHER
12. Name: John Prevas
13. Birthplace: Greece

MOTHER
14. Maiden Name: Katherine Pernokis
15. Birthplace: Greece

16 (a) Informant: Hospital Records
(b) Address: Union Memorial Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)
(c) Cemetery or crematory: Greek Orthodox Cem
Location: Woodlawn; Md.

18 (a) Funeral director: Harry E. Bligh Jr.
(b) Address: 4914 Belair Road

19 (a) NOV 4 1946 Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1946 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1946 to Nov. 2 1946 and that I last saw him alive on Nov 2 1946

	Duration
Immediate cause of death: Rheumatic Heart Disease	3 mths
Due to: Rheumatic Fever	1 Yr.
Due to:	
Other Conditions: Progressive Cardiac Decompensation (Include pregnancy within 3 months of death)	3 mths

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. R. McShane
Address Union Mem. Hosp. Date signed 11/2/46

VS 190

Correct all entries especially important. Physicians: please write the causes of death clearly and legibly.

G45214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G45214 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Washington Timms

3 (b) If veteran, name war: World war I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1901

8. AGE: Years	Months	Days	If less than one day
45	-	26	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Charles H. Timms
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Jennie Henson
15. Birthplace Charles Co. Md.

16 (a) Informant Bertha Timms
(b) Address 1405 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4 1946 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. George H. Holland
(b) Address 6201 Druid Hill Ave.

NOV 4 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 3a

20. DATE OF DEATH Nov 1 1946 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to Nov 1 1946 and that I last saw h.e. alive on Oct 21 1946.

Immediate cause of death: Left Hemiplegia
Hypertension
Cerebral Embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. Butler, M.D.
Address 2033 Gwynn Oak Ave Date signed 11/7/46

VS 150

G45215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Linger Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Linger Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond E. Harris Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No. 219-10-1205

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Amanda Hanna
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Dec 6 1890

8. AGE: Years	Months	Days	If less than one day
55	10	27	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Clothier Tender.
11. Industry or business Textile Mills.

FATHER
12. Name George W. Harris
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Fanny J. Cunningham
15. Birthplace Balto Md.

16 (a) Informant Raymond E. Harris
(b) Address 3732 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5 1946 (month) (day) (year)
(c) Cemetery or crematory Marshall Park
Location Taylor Ave.

18 (a) Funeral director Thompkins & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) Date rec'd by (b)
NOV 4 1946 Huntington Hillsboro, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1946, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938 to 11-3 1946 and that I last saw him alive on 11-3 1946.

Immediate cause of death	Duration
Coronary Thrombosis	6 hrs
Due to Hypertensive CVD	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Linnard M. D.
Address 5711 Falls Rd Date signed 11-7-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G45216
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 Harrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Harrison Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Cushner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Jacob -
13. Birthplace Russia

MOTHER
14. Maiden Name Cook
15. Birthplace Russia

16 (a) Informant W. H. Cushman
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory Interred Herbert Cem.
Location Wash. Blvd.

18 (a) Funeral director Jacob Russo
(b) Address 1134 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 4 1946
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1946 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 4 1946 and that I last saw h alive on Nov 3 1946

Immediate cause of death Coronary Thrombosis — Duration 3 days
Due to Chronic Myocarditis & Hypertension — 4 yrs
Due to Coronary Sclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cushman M.D.
Address 1921 W Lorraine Ave Date signed 11/4/46

X

G45217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200a

G45217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 East Eaton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. James Silberman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10 1876

8. AGE: Years	Months	Days	If less than one day
70	-	22	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name deceased

13. Birthplace Russia

MOTHER 14. Maiden Name deceased

15. Birthplace Russia

16 (a) Informant Jennie Adler

(b) Address 2003 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-46 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Putty Hill Rd

18 (a) Funeral director Jack Levin Lyon

(b) Address 1432 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 4 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2/ 1946, at 11 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/ 1946 to 11/2 1946, and that I last saw him alive on 11/2/ 1946.

Immediate cause of death Overdose

Antecedent cause

Cause undetermined

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. W. Mantz

Address St Agnes Hosp Date signed 11/3/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45218

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3925 Fairview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3925 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Bressler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Ret
11. Industry or business

FATHER
12. Name Jos. R.
13. Birthplace

MOTHER
14. Maiden Name Rachael
15. Birthplace R.

16 (a) Informant Anna Bressler
(b) Address 3925 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Gunman Rd. & Belair Rd

18 (a) Funeral director Post, Neura Inc
(b) Address 1419 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 NOV 4 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946 at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Nov 3 1946 and that I last saw h.i. alive on 3 Nov 46.

Immediate cause of death: Coronary Thrombosis — Duration: 4 Mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob M Miller M. D.
Address 1419 E. Balto. St. Date signed 11-4-46

X

G45219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1567

G45219 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2721 Mura St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 Mura St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Einar B. Davidsen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13-1901

8. AGE: Years 45 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Norway
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Oli. Davidsen
13. Birthplace Norway

MOTHER 14. Maiden Name Stein
15. Birthplace Norway.

16 (a) Informant Helen Davidsen
(b) Address 2721 Mura St.

17 (a) Burial (b) Date thereof Mr. 6-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Key-Bath.
Location Old Frederick Rd.

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Baltimore St.

19 (a) NOV 1946 (b)
(Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 46 to Nov. 1 1946, and that I last saw him alive on Nov. 1 1946.

Immediate cause of death
Bowel Tumor
Due to Primary
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2 Yrs 8 Mos
over

Date of operation 1946
Major findings of operation Bowel Cancer Inoperable
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry J. Zeugas M.D.
Address 700 E. Fayette St. Date signed 11-7-46

VS 150

G45220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G45220

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] Rd.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Middle Revia (If outside city or town limits, write RURAL and give town)
(d) Street No. 42 Hawthorne (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Schneider

3 (b) If veteran, name war: World War 1~
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife: Rose,
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 3, 1896
8. AGE: Years 50 Months 8 Days 1 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation furniture finisher
11. Industry or business

FATHER
12. Name Christian Schneider
13. Birthplace Md.

MOTHER
14. Maiden Name Augusta Pfefferjen
15. Birthplace Md.

16 (a) Informant Mrs. Rose Schneider
(b) Address Route 15 - Box 111 Middle River, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 210 Fredk. Ave.

19 (a) (Date rec'd by registrar) NOV 4 1946 (b) Huntington & Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 4 1946 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1946 to 11-4 1946 and that I last saw him alive on 11-4 1946.

Immediate cause of death: Cardiac failure — Duration:
Due to: myo cardial infarction & pulmonary oedema
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. A. Clark, M.D.
Address University Hosp. Date signed 11-5-46

G45221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45221 Registered No.

Please write the causes of death clearly and legibly. Physicians: please see that information as to age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Poplar Grove St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Mary Louise Salmon

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/1862

8. AGE: Years 83 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired Housewife
11. Industry or business

FATHER
12. Name Wm. J. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Hattie A. L. Davis
15. Birthplace Maryland

16 (a) Informant R. L. Salmon
(b) Address 122 S. Calvert Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George L. Lahmert
(b) Address 2101 Frederick Ave.

19 (a) (Signature of person who supplied data) (b) Address Huntingtown, Williamsport, Md.

NOV 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1946, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946, to November 1946, and that I last saw h[illegible] alive on Nov 2 1946

Immediate cause of death Arteriosclerotic C.V. Disease (Coronary Occl.) — Duration 10 yrs
Due to with Complications
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 W. Fulton Ave Date signed 11/2/46

X

H0 3409

G45222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157E

G45222 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Calif. (b) County
(c) City or town Ebonte
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Bodger Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marilyn Lee Tinsson

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-42

8. AGE: Years	Months	Days	If less than one day
4	1	12	hr. min.

9. Birthplace Calif.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Arthur Tinsson
13. Birthplace Oklahoma

MOTHER
14. Maiden Name Jewell Taylor
15. Birthplace Oklahoma

16 (a) Informant Parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Rose Hill
Location Whittier, Calif.

18 (a) Funeral director John B. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Registrar Huntington Hill, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1946 at 10 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30, 1946 to Nov. 2 1946 and that I last saw ~~him~~ her alive on Nov. 2 1946

Immediate cause of death Encephalomalacia
Cerebral anoxia — Duration ?

Due to Tetralogy of Fallot + Operation — Duration Life

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Tetralogy of Fallot
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry T. Bahnson M. D.
Address Johns Hopkins Hospital Date signed 11/6/46

VS 150

G45223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registration No. G45223

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Bannister

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-12-0952

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1924

8. AGE: Years	Months	Days	If less than one day
22	3	18	hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)

10. Usual Occupation Driver

11. Industry or business

FATHER 12. Name James Bannister
13. Birthplace Calvert County Md

MOTHER 14. Maiden Name Beatrice Bowmer
15. Birthplace Calvert County Md

16 (a) Informant James Banquelp
(b) Address 612 So Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 661 West Baltimore Street

19 (a) (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS-150

NOV

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1946, at 9:26 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1946 to 11-1 1946, and that I last saw h[illegible] alive on 11-1 1946

Immediate cause of death	Duration
Terminal Cachexia with Hydrothorax, ascites, etc	2 Days
Due to Malignant Disease	Diagnosed in June 1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Morrison M. D.
Address Univ. Hospital Date signed 11/1/46

X

G45224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St.
(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S. FRANKLINTOWN, Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country GREECE

3 (a) FULL NAME STANLEY THEODORE BAHLIVAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	MARRIED

6 (b) Name of husband or wife MRS. S. T. BAHLIVAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-1895.

8. AGE: Years	Months	Days	If less than one day
51	4	21	hr. min.

9. Birthplace GREECE (Town, county, and state)
10. Usual Occupation BAKER
11. Industry or business BAKERY

FATHER
12. Name THEODORE BAHLIVAN
13. Birthplace GREECE

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant MRS. STANLEY BAHLIVAN
(b) Address 301 S. FRANKLINTOWN RD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-4-1946 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Baltimore Md.

18 (a) Funeral director Durward D. Covington
(b) Address 21 W. 23rd ST

19 (a) Received by registrar NOV 4 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/1946 at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1946 to 11/1 1946 and that I last saw him alive on 11/1 1946.

Immediate cause of death: Coronary Occlusion — Duration 10

Due to: Arteriosclerotic Heart Disease — Duration ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Union Memorial Date signed 11/1/1946 M. D.

Huntington Williams, M.D.

Hospital X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G45225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 S. Sharp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yr
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 S. Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Staten

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Edward Merrill
13. Birthplace md

MOTHER 14. Maiden Name Elizabeth —
15. Birthplace md

16 (a) Informant Victoria Wilson
(b) Address 1143 N. Fulton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stayer
(b) Address 1142 Woodall St

19 (a) (Date received by registrar) (b) NOV 4 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1946, at 8 a.m.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-10 1946 to 11/2 1946 and that I last saw h[illegible] alive on 11/1 1946

Immediate cause of death Cardio Renal — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. M. Hatchew
Address 1111 Pa Ave Date signed 11/4/46

Huntington Williams M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered G45226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Laurenella

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Gustav Saumalle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1876

8. AGE: Years 70 | Months 0 | Days 45 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Mr. Charles H. Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa J. Hughes
15. Birthplace Maryland

16 (a) Informant Mr. Wm M. Justis Jr.
(b) Address 711 Cedarcroft Rd

17 (a) Burial (b) Date thereof 11/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2004 Gilsons St

19 (a) (b) 1946
(Date rec'd by registrar)
Assistant Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/46 19 , at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weems M.D.
Medical Examiner.
Date signed 11/1/46

G45227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G45227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road & List Ave.
(c) Hospital or institution:
Harford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 S. Dean St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara C. Appel

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Conrad Appel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	8	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Nicholas Winkler
13. Birthplace Germany

MOTHER
14. Maiden Name Dont know
15. Birthplace Germany

16 (a) Informant Mrs. Mary Mielke
(b) Address 717 S. Dean St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)
(c) Cemetery or crematory First German United
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1946 19 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Nov 2 1946 and that I last saw him alive on Nov 1 1946.

Immediate cause of death	Duration
Diabetic malitis, & subsequent gangrene both legs. Diabetic coma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Buckman M. D.
Address 3179 C. Baltimore Date signed 11-9-46

VS 150

Huntington Williams, Md

X

G45228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

G45228

Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 E. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Martin, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	214-01-5669

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Stella Martin
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1898

8. AGE: Years	Months	Days	If less than one day
47	11	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Automobile mechanic
11. Industry or business

FATHER
12. Name Harry Martin
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillie M. Hatton
15. Birthplace Baltimore, Md.

16 (a) Informant George Martin, Jr.
(b) Address 2810 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1946 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 19 46 to 10/31 1946, and that I last saw him alive on 10/31 1946.

Immediate cause of death	Duration
Tumor of frontal lobe (consecutive)	10 months
Due to Intracranial Tumor	
Due to (Causing me)	10 months
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 2320 Eutaw Pl Date signed 11/1/46

VS 150

Hunting for [illegible]

X

G45229 446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G45229 · Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 9 ~~JOHNS HOPKINS HOSPITAL~~ ~~JOHNS HOPKINS HOSPITAL~~
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 E Fortheve
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Mennenger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-62

8. AGE: Years	Months	Days	If less than one day
84	0	19	hr. min.

9. Birthplace Penn —
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Henry Mennenger
13. Birthplace Penn.

MOTHER 14. Maiden Name Augusta ?
15. Birthplace Germ.

16 (a) Informant Records.
(b) Address ~~JOHNS HOPKINS HOSPITAL~~

17 (a) Burial (b) Date thereof 11/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulman Funeral Home.
(b) Address 2604 Pelham Ave

19 (a) NOV 4 (b) 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

25

20. DATE OF DEATH Nov. 3 1946 at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1946 to Nov 3 1946 and that I last saw him alive on Nov 3 1946

Immediate cause of death Heart failure (Complications) — Duration

Due to Long standing heart disease etiology undetermined

Due to

Other Conditions Chronic bronchial asthma

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert S Donahue M.D.
Address 1414 Date signed 11-5-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45230 — 92 B — R-G45830

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 13- 4- 13-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Duncan Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Delores Smith Jenzkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19-1933

8. AGE: Years	Months	Days	If less than one day
13	4	13	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace ?

MOTHER
14. Maiden Name Gertrude ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary / Holy Redeemer
Location Baltimore, Md

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 600 S Caroline

19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1946, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1946, to Nov. 2 1946 and that I last saw her alive on Nov. 2 1946

	Duration
Immediate cause of death Heart Failure	
Due to Rheumatic Heart Disease	1 mos.
Due to	
Other Conditions Mitral Stenosis & Insuf. Aortic Stenosis & Insuf. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Bayhutt M. D.
Address Balt. City Hosp. Date signed 11-

VS 150

G45231

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Keys

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	Colored	

6 (b) Name of husband or wife Victoria C. Keys
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1891

8. AGE: Years	Months	Days	If less than one day
55	7	5	hr. min.

9. Birthplace King Queen Co., Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant Victoria Keys
(b) Address 1729 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946, at 4.25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage from ruptured aneurysm of aorta.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/1/46

G45232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 936 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gambrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race N | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Bessie Gambrell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-22-1884

8. AGE: Years 62 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Hilliston, S.C.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jessie Gambrell
13. Birthplace S.C.

MOTHER
14. Maiden Name Sylvia ?
15. Birthplace S.C.

16 (a) Informant Lloyd Gambrell
(b) Address 936 Madison Ave.

17 (a) Burial (b) Date thereof 11-7-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Anderson, S.C.

18 (a) Funeral director Charles R. Law
(b) Address 902 Madison Ave

19 (Date received by registrar) NOV 4 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1946 at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1946 to Nov 2 1946 and that I last saw him alive on Nov 2 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 10 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature — Dr. Goosey

Address 732 Eutaw St Date signed 11/4/46

JL - 103098

G45233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G45233 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 McHenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Mignot

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Barney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1886

8. AGE: Years	Months	Days	If less than one day
60	3	19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Wilton Merson
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Jones
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) burial (b) Date thereof 11/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 2930 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 4 1946

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1946, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1946, to Nov. 2 1946, and that I last saw her alive on Nov. 2 1946

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Fractured neck of left femur. Cerebral atrio. (Include pregnancy within 3 months of death)

Date of operation 7/23/46

Major findings of operation: Fractured neck of left femur

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 7/22/46 M
(c) Where did injury occur? 735 McHenry St. Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? Yard
(e) Means of injury: Fall on floor. Fell.

23. Signature H. F. Gibbs, M.D.
Address Balto. City Hospitals Date signed 11/5/46

To be approved by Medical Examiner
for Dr. J. M. Davis, by Howard J. Lowndes, M.D.

G45234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G45234 Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Katherine Prenger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1893

8. AGE: Years 53 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Registered Nurse

11. Industry or business Mercy Hosp.

FATHER
12. Name John Prenger
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Brannan
15. Birthplace Ireland

16 (a) Informant Mary E Prenger
(b) Address 717 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-46. (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Frederick Rd.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (b)
Registrar

Date rec'd by Registrar NOV 4 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1946, at 6:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1946 to 11-2 1946 and that I last saw her alive on 11-2 1946.

Immediate cause of death: Respiratory failure — Duration

Due to cerebral hemorrhage

Due to hypertensive arterio-sclerotic C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May
Address Calvert + Saratoga Sts. Date signed M. 11- D. 2-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G45235 BALTIMORE CITY HEALTH DEPARTMENT ✓ G45235

CERTIFICATE OF DEATH 131a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write this correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 786 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 786 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis A. Balle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1900

8. AGE: Years	Months	Days	If less than one day
46	1	13	hr. min.

9. Birthplace Rudeville Va. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Lewis H. Balle
13. Birthplace Balto Md

MOTHER
14. Maiden Name Cora Kiel
15. Birthplace Rudeville Va.

16 (a) Informant Carrie Brooks
(b) Address 2033 W. Gilmor St.

17 (a) Burial, cremation, or removal Shipped (b) Date thereof Oct. 4 1946 (month) (day) (year)
(c) Cemetery or crematory Fredericksburg Va.
Location

18 (a) Funeral director Mc Kato & Pellegrini
(b) Address 29 W. Schroeder St

19 (a) 1946 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1946 to Oct. 1 1946 and that I last saw h alive on Oct. 3 1946.

Immediate cause of death	Duration
Coronary Thrombus	
Due to Heart Disease	6 Months
Due to High Blood Pressure	1 Year
Other Conditions Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Skelton M.D.
Address 905 E. Baltimore St. Date signed 10/4/46

Huntington Williams, Md

G45236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G45236

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 E. 37th Street
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 E. 37 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary Agnes Fisher

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Charles Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30-1869

8. AGE: Years 77 Months 1 Days 1 If less than one day hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business —

FATHER
12. Name William Hazelheim
13. Birthplace Maryland

MOTHER
14. Maiden Name Dibaw
15. Birthplace Maryland

16 (a) Informant Mrs. Lottie V. Griffith
(b) Address 3678 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) 1946 Thurston for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1- 1946 at 10:46 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1946 to Nov 1st 1946 and that I last saw h alive on Nov 1st 1946

Immediate cause of death Cerebral hemorrhage due to Senile arteriosclerosis Duration 1 yr
Due to H.C. senility.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D.G. Williams M. D.
Address 2611 Fallsway Date signed Nov 2nd 46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45237 BALTIMORE CITY HEALTH DEPARTMENT G45237
CERTIFICATE OF DEATH 137a
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 450a Mary Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WID.

6 (b) Name of ~~husband~~ or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1869

8. AGE: Years	Months	Days	If less than one day
76	11	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Keefer
15. Birthplace Maryland

16 (a) Informant Mrs. Lucille Brooks
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1946 at 6 42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1946 to Nov. 2 1946, and that I last saw h alive on 19

Immediate cause of death: Respiratory failure — Duration: 6 days

Due to Cerebral-Vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10/17/46
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature August Kiel
Address Mercy Hosp. Date signed 11-2-46 M. D.

VS 150

G45238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G45238 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Stone House Cove, Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Copper

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1929

8. AGE: Years	Months	Days	If less than one day
17	3	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Merchant Seaman
11. Industry or business

FATHER
12. Name William E. Copper
13. Birthplace Md

MOTHER
14. Maiden Name Katie Grey
15. Birthplace Md

16 (a) Informant Mr William Copper
(b) Address Stone House Cove

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John J Kenny Inc
(b) Address 718 Light St.

(c) Date received by registrar 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946, at 1.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage
Fractured cervical vertebra
Fractured left femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: D.A. Bc.
(a) Date of injury 10-27-46 at 11.30 P.M.
(b) Where did injury occur? Piney Creek - Riveria Beach, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger motor cycle - ran into auto

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11- 1-46

VS 181

G45239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G45239 14

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd. & Herring Run.
(c) Hospital or institution: Spelman Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD, Box 542
(If no street, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CROMWELL, ROSIE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
24(?)			hr. min.

9. Birthplace Skidmore, MO.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Abraham Cromwell
13. Birthplace MO.

MOTHER
14. Maiden Name Etta Hayes
15. Birthplace ~~Mo~~ MO.

16 (a) Informant Etta Hayes
(b) Address RFD, Box 542, Annapolis

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7 1946 (month) (day) (year)
(c) Cemetery or crematory Broadneck
Location St Bridgetta R.C. Co.

18 (a) Funeral director J. Edmonds Sons
(b) Address Annapolis.

19 (a) Filed by (b) [illegible]

1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1946, to 11-4- 1946, and that I last saw h-r alive on 11-4- 1946.

Immediate cause of death Respiratory failure — Duration

Due to Tuberculous Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peggy Ann Hanson. M. D.
Address Sydenham Hospital Date signed 11/4/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45240

BALTIMORE CITY HEALTH DEPARTMENT 168 G45240

CERTIFICATE OF DEATH

Registered No. 1900 Thames St.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Romero

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
30 ?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)
(c) Cemetery or crematory Locust Hill
Location Severn Rd.

18 (a) Funeral director Lilly & Zadek
(b) Address 423 S. Paca St.

19 (a) 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946, at 12.05 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to 2nd & 3rd degree burns involving 65% body surface

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-46 4 a. M.
(b) Where did injury occur? 1900 Thames
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Explosion - followed by fire.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 10-31-46

G45241

BALTIMORE CITY HEALTH DEPARTMENT 168 G45241 Registered No.

CERTIFICATE OF DEATH 1700 Thames St.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns HopkinsHospital. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore.
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Marco Tulio (Estonosio)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 30-? Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Glenn Hill Rd

18 (a) Funeral director Lilly & Zadoian
(b) Address 403 S. [illegible]

19 (a) 1946 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1946 a, at 5.15 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock from burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-46 4.20 a. M.
(b) Where did injury occur? 1700 Thames St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Explosion

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10-31-46

G45242

BALTIMORE CITY HEALTH DEPARTMENT 168 G45242

CERTIFICATE OF DEATH 1700 Thames St. Baltimore

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Cuba (b) County
(c) City or town Havana (If outside city or town limits, write RURAL and give town)
(d) Street No. Oficios 239 (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Cuba

3 (a) FULL NAME Raul ~~Santanes~~ Francisco Santana

MEDICAL CERTIFICATION

3 (b) If veteran, name war

3 (c) Social Security Account No.

20. DATE OF DEATH Oct. 31, 1946, at 5.15 P.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock from burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
41 (30-1)			hr. min.

9. Birthplace Regla, Havana Cuba (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Merchant Marine

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Juana Santana

15. Birthplace

16 (a) Informant Julian Consolate

(b) Address Balls Pt. Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Location Hollins Ferry Rd

18 (a) Funeral director Lilly & Zeller Sons

(b) Address 403 S. Broadway

19 (a) 1946 (Date rec'd by registrar) (b) Tom Williams, M.D. Registrar

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-31-46 4.20 A.M.

(b) Where did injury occur? 1700 Thames St.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No

(d) Means of injury Explosion

23. Signature George L. Merrill M.D. Medical Examiner

Date signed 10-31-46

VS 181

G45243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45243 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore Dundalk
(a) State MD (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002- Woodland Ave. 202 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Carver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age 1901 years

7. Birth date of deceased (mo., day, yr.) May 1st (1901)

8. AGE: Years	Months	Days	If less than one day
40 45 (46)	6	-	hr. min.

9. Birthplace Eldorado [illegible]
10. Usual Occupation Painter (sign)
11. Industry or business Paint Shop Chem. Curtis Bay

FATHER
12. Name George Carver
13. Birthplace Eldorado

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Anna Carver
(b) Address 202 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Whitney Point N. York

18 (a) Funeral director Leo F. Cook
(b) Address 201-03 N. Patterson Park Ave

19 (a) Date received 1946 (Registrar) Huntington Williams, M.D. Registrar

NOV 4

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946, 10.15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fractured skull
Laceration and contusion of brain
Due to Fractured cervical vertebrae
Fractured rib

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-1-46 9.30a 25/5 M.
(b) Where did injury occur? (Give address) Chem. Curtis Bay
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Fell over hot pipe

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 11-1-46

G45244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G45244 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: "est Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 Roslyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace Bruce Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	No	female	white	married

6 (b) Name of husband or wife Frank P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1873

8. AGE: Years	Months	Days	If less than one day
73	3	5	hr. min.

9. Birthplace Trappe, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name Drucilla Ann Merrick
15. Birthplace Md.

16 (a) Informant Mr. John E. Marshall
(b) Address 2608 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania "ves

19 (a) (b) (Date rec'd by reg.) Huntington Williams, Registrar
NOV 4 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1946 to 11/2/1946, and that I last saw her alive on 11/1/1946.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: 10 yrs (?)
Due to: Coronary Heart Disease, Chronic Renal Disease — 2 6 yrs
Due to: Generalized Arterio-Sclerosis — Unknown
Other Conditions: — 12 yrs

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Trenbil M. D.
Address 142 W Park Ave Date signed 11/4/46

G45245

BALTIMORE CITY HEALTH DEPARTMENT ✓ G45245

CERTIFICATE OF DEATH 73a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3729 Nortonia Rd.
(c) Hospital or institution: 15 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3729 Nortonia Rd. 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATTHEW JACKSON ASKEW

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 712-14-9666

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Martha G. Askew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1867

8. AGE: Years	Months	Days	If less than one day
79	2	1 2	hr. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)
10. Usual Occupation Retired Cashier
11. Industry or business R. R. Express Co.

FATHER
12. Name Robert Askew
13. Birthplace England

MOTHER
14. Maiden Name Mahalda Leeds
15. Birthplace Ohio

16 (a) Informant Mrs. Martha G. Askew
(b) Address 3729 Nortonia Rd.

17 (a) Burial (b) Date thereof 11/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1946 Huntington Williams, M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1946, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1938 to Nov. 2, 1946, and that I last saw him alive on Nov. 2, 1946.

Immediate cause of death	Duration
Vascular collapse	3 days
Due to Pernicious anemia	8 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice L. Shamer M. D.
Address 3300 W. North Ave. Date signed 11-4-46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

G45246

CERTIFICATE OF DEATH

Registered No. 1225

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Hamilton Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Bender

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age
7. Birth date of deceased (mo., day, yr.) August [redacted]

8. AGE: Years	Months	Days	If less than one day
58	2	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cream, Cont, + Seal
11. Industry or business

FATHER
12. Name Alfred Bender
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Long
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Virginia Kelly
(b) Address 2709 White Gros.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/46 (month) (day) (year)
(c) Cemetery or crematory Hope Well
Location Port Deposit, Md.

18 (a) Funeral director Charles E. Schmidt
(b) Address 760-62 E. Madison St.

19 (a) 1946 (Date rec'd by Registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1946, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1946 to Nov. 2 1946, and that I last saw h[illegible] alive on Nov. 2, 1946.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Intestinal Obstruction & generalized peritonitis	3 Days
Due to	
Other Conditions Chronic Alcoholism	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Connor M. D.
Address Mercy Hospital Date signed 11-2-46

Connor X

G45247 ✓ G45247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dist
(c) Hospital or institution: John Hopkins Hospital 9N
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 E Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Melka ✓

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife: late Frances Melka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1870

8. AGE: Years	Months	Days	If less than one day
76	4	10	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Frank Melka.
13. Birthplace Czech.

MOTHER
14. Maiden Name Anna Peska.
15. Birthplace Czech.

16 (a) Informant Edward Svatos nephew
(b) Address 2419 East Eager St
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & Belt Ave
18 (a) Funeral director P. Salamunovich
(b) Address 1601-03 E. Madison St
19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1946, at 4:56 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to
Illuminating gas
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/2/46 at about 2 P.M.
(b) Where did injury occur? 1819 E. Eager St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas inhalation Suicide

23. Signature P. Salamunovich M.D.
Medical Examiner.
Date signed 11/3/46

VS 191

G45248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G45248 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3722 Glenmore Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Collinsworth

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Robt. Lee Collingsworth
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) April 28, 1872

8. AGE: Years	Months	Days	If less than one day
74	6 5	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Klemm
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Unknown
15. Birthplace Germany

16 (a) Informant Robert Lee Collingsworth
(b) Address 3722 Glenmore Ave,

17 (a) Burial (b) Date thereof 11/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 201 W. Lombard St.

19 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1946, 4:50 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1946 to Nov 1 1946; that I last saw him alive on Nov 1 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	Oct 24/46
Due to Hypertension	about 2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Sankin M. D.
Address 100 N. Milton Ave Date signed 11/4/46

VS 150

G45249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G45249 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Charles County
(c) City or town Waysise
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Louise Lenpiere

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	black	Mary

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-46

8. AGE: Years	Months	Days	If less than one day
		1 Day	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nelson - Lenpiere
13. Birthplace ? , ,

MOTHER
14. Maiden Name Harriett Louise Ford
15. Birthplace ? , ,

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 4 - 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-1946, at 2 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946 to 10-23-1946, and that I last saw h alive on 10-23-1946.

Immediate cause of death PREMATURITY — Duration LIFE

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul M. Hardy M. D.
Address JOHNS HOPKINS HOSP. Date signed 10-24-46

VS 150

G45250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45250 Registered No.

V1242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CATON & WILKENS AVE.
(c) Hospital or institution: ST. AGNES HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State WASH. DC (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 362 MASSACHUSETTES AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILOPIMIN VOUNESSOPOULOS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife CALIOPE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day hr.	min.
47				

9. Birthplace (Town, county, and state)

10. Usual Occupation REPRESENTATIVE

11. Industry or business GREEK EMBASSY

FATHER 12. Name Nick Vounessopoulos

13. Birthplace GREECE

MOTHER 14. Maiden Name unknown

15. Birthplace Greece

16 (a) Informant James H. Sfakianakis

(b) Address 8 N. Linwood Ave Balto

17 (a) Burial (b) Date thereof 11/4/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mayoral City
Location To Athens, Greece Mayoral Co

18 (a) Funeral director W. W. Chambers Co

(b) Address Washington, D.C.

19 (a) 1946 (b) Registered by registrar Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1946, to 11-4 1946, and that I last saw him alive on 11-4 1946

Immediate cause of death	Duration
Cardiac Failure	
Due to Acute Cardiac Dilatation	
Due to	
Other Conditions Hepatitis-chronic	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry V. Hollies M. D.

Address St. Agnes Hosp Date signed 11-4-46

Correct age is especially important. Physicians please write the causes of death clearly and legibly.

G45251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45251 Registered No. 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7101 Old Spring Lane
(c) Hospital or institution: Old Spring Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) The 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) The 24 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Eastport
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy B. Smith

3 (b) If veteran, name war — 3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11, 1896

8. AGE: Years	Months	Days	If less than one day
50	9	23	hr. min.

9. Birthplace Anne Arundel County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Alexander Smith
13. Birthplace Anne Arundel Co., Md.

MOTHER
14. Maiden Name Annie Hawkins
15. Birthplace Anne Arundel County, Md.

16 (a) Informant Mr. Charles B. Smith
(b) Address Eastport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 1005 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV. 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 3 1946, at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 10 1946 to Nov 3 1946, and that I last saw h[illegible] alive on Nov 2 1946;

Immediate cause of death: CARCINOMATOSIS — Duration 2 mos.
Due to CARCINOMA - Caecum. — 18 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Klemm M. D.
Address 3803 Edmondson Date signed 11/3/46

Correct age is especially important. Physicians please write the causes of death clearly and legibly.

G45252 BALTIMORE CITY HEALTH DEPARTMENT G45252
Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3645 Park Heights ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3645 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth McLean

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Franklin Dixon McLean
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 21, 1865

8. AGE: Years	Months	Days	If less than one day
81	—	14	hr. min.

9. Birthplace Balto. County Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Jackson Ahler
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ann Ryland
15. Birthplace Maryland

16 (a) Informant Violet McLean
(b) Address 3646 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

NOV 5 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1946, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946, to Nov 4 1946, and that I last saw h w alive on Nov 4 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	11/1/46
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. D. Burbert M. D.
Address 883 Park Heights Ave Date signed 11/4/46

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3973 G45253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45253 Registered No. 46a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Latrobe Latrobe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Jamison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Potthoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Teresa Potthoff
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 12-18-74

8. AGE: Years	Months	Days	If less than one day
71	10	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Watch maker
11. Industry or business

FATHER 12. Name Henry Potthoff
13. Birthplace Germany

MOTHER 14. Maiden Name Anna Pastor
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 11-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Vincents
Location W. Ponland Co., Penna.

18 (a) Funeral director Tirbow & Sons
(b) Address Mt Pleasant Ave Balto. 14

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 4 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 - 2 1946, to 11 - 4 1946, and that I last saw him alive on 11 - 4 1946.

Immediate cause of death INANITION — Duration

Due to Ca esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-11-46; 10-12-46

Major findings of operation: Carcinoma esophagus, inoperable

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard P. Clay
Address John Hopkins Hosp Date signed 11/7/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 150

G45254
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W Lexington St
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Catherine Hobbs

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1862

8. AGE: Years	Months	Days	If less than one day
84	0	26	17 hr. min.

9. Birthplace Stablersville Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wesley Royston Cuddy
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Rachel Ann Stabler
15. Birthplace Md.

16 (a) Informant Emily Bauchet
(b) Address Home for Incurables

17 (a) Burial (b) Date thereof 11/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1946 (b) Huntington Williams, Reg.
(Date rec'd by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4th 1946, at 5.27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938 to Nov. 4th 1946, and that I last saw h[illegible] alive on Nov. 2nd 1946

Immediate cause of death	Duration
Carcinoma of Breast with metastases	7 yrs
Due to	
Due to	
Other Conditions Arteriosclerotic Cardio Vascular Disease	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St. Baltimore 2, Md. Date signed Nov. 4 1946

G45255 G45255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Joseph Watts

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 225-05-2522

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Lucy Rate Watts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25th 1871

8. AGE: Years	Months	Days	If less than one day
75	7	8	hr. min.

9. Birthplace Talbott Co. Md.
(Town, county, and state or foreign country)
10. Usual Occupation Settlement Clerk
11. Industry or business B & O R.R.

FATHER
12. Name (Unknown) Watts
13. Birthplace "

MOTHER
14. Maiden Name ?
15. Birthplace "

16 (a) Informant William Robert Watts
(b) Address 610 Dartford Rd.

17 (a) Burial (b) Date thereof 11/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1946, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1945, to Nov 3 1946, and that I last saw [illegible] alive on Nov 3 1946.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 E. North Ave Date signed 11/4/46

VS 150

cause age is especially important. Physicians: please write the causes of death clearly and legibly.

G45256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G45256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3718 Old York Rd.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3718 Old York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna F. Hildebrand

3 (b) If veteran, name war: W
3 (c) Social Security Account No. DUE

4. Sex: Female
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of husband: Jacob M. Hildebrand
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 24 1894

8. AGE: Years	Months	Days	If less than one day
52	6	10	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John Kalinowski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Gosliszeska
15. Birthplace Poland

16 (a) Informant Jacob M. Hildebrand
(b) Address 3718 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Nov 4 1946, and that I last saw ~~her~~ alive on Nov 3 1946.

Immediate cause of death	Duration
Uterine Carcinoma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer, M.D.
Address 506 E. North Ave Date signed 11-7-46

VS 150

Hunting for Williams, Md

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45257 BC# G60401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45257 Registered No. 1579

Please write the causes of death clearly and legibly. Physicians: please fill out every item. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5105 Edgar Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Giannaccini

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/27/46

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Angelo J. Giannaccini
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dolly Margaret Frangoni
15. Birthplace Nelson, Georgia

16 (a) Informant Records of Bon Secours Hosp.
(b) Address Balto., Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5 46
(c) Cemetery or crematory Holy Redeemer Cem. Location Bolair Road, Frederick Rd

18 (a) Funeral director Frank J. Pipitone
(b) Address 2818 E. Baltimore St.

19 (a) NOV 5 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1946, to Nov 4 1946 and that I last saw her alive on Nov 4 1946

Duration

Immediate cause of death: Respiratory failure
Due to: Congenital Cholecystitis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M.D.
Address Bon Secours Hosp. Date signed 11-7-46

VS 150

G45258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G45258
Registered No.

Please write the causes of death clearly and legibly. Physicians; please write the exact age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt. 1510
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Springdale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELI GORFINK

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-1134

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hyman Rosenberg
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-46 (month) (day) (year)
(c) Cemetery or crematory Beth Tefiloh
Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) 1946 (Date rec'd by registrar) (b) Registrar
Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/46 19 at 3:50 P M

21. I certify that death occurred on the date above stated; that [attended deceased from 11/3 1946 to 11/3 1946, and that I last saw him alive on 11/3 1946

Immediate cause of death Cardiac Failure — Duration

Due to Myocardial Infarction

Due to Coronary Occlusion

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gross abnormal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Rosenberg M.D.
Address Same Date signed 11/4/46

94a

Edith Russell

G45259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

G45259 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Fremont St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1008 Fremont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Russell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30 – 1884

8. AGE: Years 61 62 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Dennis Howe
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Julia High
15. Birthplace Calvert Co Md

16 (a) Informant: Helen Howe Price
(b) Address 3380 Carrollton Ave

17 (a) Nov 6 – 46 (Burial, cremation, or removal) (b) Date thereof Nov 6-46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location Arbutus

18 (a) Funeral director J. A. Brooks
(b) Address 1463 N. Carey St

19 (a) 1946 (To be fill'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1946, at 12.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1946, to Nov 2 1946, and that I last saw h[illegible] alive on Nov 2 1946.

Immediate cause of death
(a) Intest hemorrhage
Due to Senile Psychosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
(a) 10 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 733 [illegible] Date signed 11/4/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1216

G45260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lorenzo Van Buren Dailey (Lorenzo Van Buren Dailey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1891

8. AGE: Years 55 (45) | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Alendo Dailey

13. Birthplace —

MOTHER 14. Maiden Name Nanna VanBuren Dailey

15. Birthplace —

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-46 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Balto., Maryland

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Ave.

DV (a) (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1946 at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an INSPECTION thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner

Date signed 10/28/46

G45261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G45261

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1079 W Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md — (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1079 W Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bonnie Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Dave Patterson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/1894

8. AGE: Years 52 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Essex Co Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business Home —

FATHER
12. Name Ethen Vessels
13. Birthplace Essex Co Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joseph Patterson
(b) Address 1079 W Lexington

17 (a) Removal (b) Date thereof 11-5-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Essex Co.,
Location Va

18 (a) Funeral director David L. Brown & Son
(b) Address 1014 W Mount Royal Ave
Huntington Woodlawn Md

19 (a) 11-6-46 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1946, at 9 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1946 to 11/3 1946 and that I last saw her alive on 11/3 1946

Immediate cause of death Uraemia — Duration
3 Dys

Due to Chronic Myocarditis
Hypertension

Due to Nephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Franklin M.D.

Address 1111 W Lee St Date signed 11/4/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 587

G45262
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Rutter St. Balto.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie V Solomon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1938

8. AGE: Years	Months	Days	If less than one day
7 8	11	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Prince Solomon
13. Birthplace Virginia

MOTHER
14. Maiden Name Minnie Mosely
15. Birthplace Virginia

16 (a) Informant Mrs. Minnie Solomon
(b) Address 1418 Rutter St Balt.

17 (a) Burial (b) Date thereof 11/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1946, at 7:A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1946 to Nov. 3 1946, and that I last saw h[illegible] alive on Nov. 3 1946.

Immediate cause of death	Duration
Cardio - Resp. failure	
Due to Acute Cardiac decompensation	7 days
Due to Acute Rheumatic Heart Disease	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas S. Cullen M. D.
Address Mercy Hospital Date signed 11/3/46

VS 150
1946

G45263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G45263 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 Dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E. 29th Street
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Charles A. Leach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary A. Timmerman
6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) May 3, 1876

8. AGE: Years	Months	Days	If less than one day
70	6	0	-- hr. --min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired Officer
11. Industry or business Police Department

FATHER
12. Name John T. Leach
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Jane Waddell
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Mary C. Leach
(b) Address 333 E. 29th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director W. Means Son
(b) Address 805 N. Calvert Street

19 (a) ------ (b) ------
(Date rec'd by registrar) (Signature of registrar)

NOV 8 1946 Hunting for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 October 1946, at 11:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1946 to Nov 3 1946, and that I last saw him alive on Nov 3 1946.

Immediate cause of death Resp. Failure — Duration

Due to Hepatic Insufficiency

Due to Hepatic Cirrhosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley M. Yaffe M. D.
Address Sinai Hosp Date signed 3 Nov 46

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

2843337 G45264 Fowlkes, G45264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 E. Eager
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Fowlkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - ?

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Nelson Stokes
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Perry
15. Birthplace Va.

16 (a) Interment
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem
Location Balto County Md

18 (a) Funeral director Mrs. Ruth A. Meintosh
(b) Address 1129 N. Carolina St

19 (a) 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1946 at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov 3 1946 and that I last saw her alive on Nov 3 1946.

Immediate cause of death: Myocardial infarction due to coronary thrombosis — Duration: 2 hours
Due to Arteriosclerotic heart disease — Duration:
Due to Hypertensive CV disease & cardiac failure — Duration: 3 years approximately
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. J. Davis
Address Johns Hopkins Hosp. Date signed 11/3/46

VS 150

G45265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1479

G45265
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: M. G. Hospital, Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5302 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Loy Hahn
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Albert
6 (b) Name of husband or wife Francis J. Hahn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1926

8. AGE: Years 20 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business "

FATHER
12. Name Otho Butterworth
13. Birthplace Va.

MOTHER
14. Maiden Name Rose McCauley
15. Birthplace Md (Balto.)

16 (a) Informant Mr. Francis A. Hahn
(b) Address 5302 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 1946 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1946 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Nov 3 1946, and that I last saw him alive on 19-3- 1946

Immediate cause of death Shock from Pulmonary Embolism — Duration 2 hrs
Due to Childbirth — 30 hrs
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature E. B. Eubor M. D.
Address 7201 York Rd Date signed 11-3-46

VS 150

G45266 G45266

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Lanley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Jessie Allsee

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-5181

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3 1911

8. AGE: Years	Months	Days	If less than one day
35	8	-	hr. min.

9. Birthplace King Queen Co Va (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER 12. Name Frank Jessie Allsee Sr

13. Birthplace Va

MOTHER 14. Maiden Name Sissie Granger

15. Birthplace King Queen Co. Va

16 (a) Informant Evelyn Collins

(b) Address 1803 Lanley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5-1946 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location A. A. Co. Md.

18 (a) Funeral director Robert McClellan

(b) Address 15-15 McElderry St

19 (a) NOV 3 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 19 46 at 11:47 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(Did injury occur at home, on farm, industrial place, in public place? While at work?)

(c) Means of injury

23. Signature C. F. Schmidt M.D. Medical Examiner.

Date signed 11/1/46

G45267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G45267 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1438 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fauntleroy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/27/1906

8. AGE: Years	Months	Days	If less than one day
40	8	5	hr. min.

9. Birthplace Va (Town, county and state)
10. Usual Occupation H. Wife
11. Industry or business

MOTHER / FATHER
12. Name John N. Fauntleroy
13. Birthplace Va
14. Maiden Name Rosare Wilson
15. Birthplace Va.

16 (a) Informant Bernard Fauntleroy
(b) Address 1438 N. Mount St

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) 1946 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1946, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 30 1946, to Nov. 2 1946, and that I last saw h[illegible] alive on 11/2 1946.

Immediate cause of death: Myocardial Degeneration — Duration: 24 hrs
Due to
Due to
Other Conditions Hypertension
Heart Disease.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Franklin Phillips M. D.
Address 1343 Fenwick Ave Date signed 11/4/46

VS 1

Huntington Williams, M.D.

G45268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45268 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 N. Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N Fremont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Littlejohn (Marshall)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife John Littlejohn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1858

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Georgia (State, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Frances Ross
13. Birthplace Georgia

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John Marshall
(b) Address 1218 Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1946, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1946 to Nov 3 1946, and that I last saw h[illegible] alive on Oct 28 1946

Immediate cause of death	Duration
Cardio Vascular Disease	2 yrs?
Due to Cerebral Hemorrhage	14 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burdette Van Fleet, M. D.
Address 1928 Penna Ave Date signed 11/7/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D. Registrar

G45269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45269 Registered No.

Write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1299 N. Curley St.
(c) Hospital or institution:
6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1299 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Garlin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frederick P. Garlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8-1876

8. AGE: Years 70 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Olaf Olsen
13. Birthplace Norway

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Frederick P. Garlin
(b) Address 1299 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 6 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (Signature of registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1946 to Nov. 3, 1946, and that I last saw her alive on Nov. 2, 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	36 hours
Broncho-Pneumonia	2 days
Due to: Coronary Insufficiency	6 mos.
Due to Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Antignani M.D.
Address 2942 E. Fayette St. Date signed 11/5/46

X

G45270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G45270 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 159 No. Potomac ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Hauman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 . 28 . 1889

8. AGE: Years	Months	Days	If less than one day
57	7	3 5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name John Hemler
13. Birthplace Baltimore

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John A. Hauman
(b) Address 159 No. Potomac ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 7 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore "
Location

18 (a) Funeral director Philip Herwig Sons
(b) Address 2224 Orleans St

19 (a) 1946 (Date filed by registrar) (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 3 1946, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 28 1946 to 11 - 3 1946 and that I last saw h.e.r. alive on 11 - 2 1946.

Immediate cause of death: Pulmonary Embolism — Duration

Due to: Post operative - a gastro-enterostomy & cholecystectomy was done [illegible] of acute bowel obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10 - 29 - 46

Major findings of operation: Blockage of Jejunum 5 inches beyond Treitz-Ligament junction by Carcinoma

Findings of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Martin M. D.
Address Md. Gen. Hosp. Date signed 11-5-46 M. D.

VS 150

G45271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45271 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3911 Canterbury Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs ?

2. USUAL RESIDENCE OF DEASCED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Canterbury Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Winthrop Preastman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Benj. Cattell Preastman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1862

8. AGE: Years	Months	Days	If less than one day
84	6	29	hr. min.

9. Birthplace Cambridge, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Pitt Dooger
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Maria Whittington Dooger
15. Birthplace Cambridge Md

16 (a) Informant Louise P. Preastman
(b) Address 3911 Canterbury Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6 1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Henry H. Jenkins Sons Co
(b) Address Mc Cullh & Orchard Sts

19 (a) (Name and address of informant) (b) (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1939 to Nov 4 1946. I last saw h[illegible] alive on Nov 4 1946.

Immediate cause of death: Arteri-sclerosis myocarditis — Duration Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H Moody
Address 1402 Park Ave. Date signed 11/3/46 M.D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45272 Registered No.

Correct and fill especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 E Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 E Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate M. Hess.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widow

6 (b) Name of husband or wife Frank J. Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1865

8. AGE: Years	Months	Days	If less than one day
81	-	9	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business None

FATHER
12. Name Frederick Hess.
13. Birthplace Va.

MOTHER
14. Maiden Name Ellen Fuel
15. Birthplace Virginia

16 (a) Informant Henry B Hess
(b) Address 2022 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Frederick Road

18 (a) Funeral director John C Mosser
(b) Address 3000 E Baltimore St

19 (a) (b)

NOV 6 1946
Date rec'd by registrar Livingston Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4, 1946 to Nov. 4 1946, and that I last saw her alive on Nov. 3 1946.

Immediate cause of death	Duration
Myocarditis Chronic	1 year
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene L. Cornforth M. D.
Address 514 Overry Lane Date signed 11/4/46

VS 150

G45273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G45273 Registered No.

Please write the causes of death clearly and legibly. Physician: please write in ink.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 Markland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 405 Markland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. Ostendorf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Henry C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1884

8. AGE: Years	Months	Days	If less than one day
62	1	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name James Connelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Ward
15. Birthplace Ireland

16 (a) Informant Henry C. Ostendorf
(b) Address 405 Markland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John G. Horan
(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 6 1946 Registrar for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Sept 1946 to 2 Nov 1946 and that I last saw h[illegible] alive on 2 Nov 1946

Immediate cause of death Aortic Stenosis

Due to

Due to

Other Conditions Arteriosclerotic Cardiovascular Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D.
Address 501 Sheridan Ave. Date signed Nov 6 46

X

G45274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

G45274 Registered No.

Write the causes of death clearly and legibly. Physicians: please write if cancer is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Canterbury Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G. Erdman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Catherine A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29-1891

8. AGE: Years	Months	Days	If less than one day
55	3	6 5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Ofc Police

FATHER
12. Name John G. Erdman
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine M. Barea
15. Birthplace Md.

16 (a) Informant Mrs. Catherine A. Erdman
(b) Address 2610 Canterbury Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-46 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5805 Harford Rd

19 (a) (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946 at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1946 to Nov. 3 1946 and that I last saw h/is alive on Nov. 3 1946.

Immediate cause of death Cerebral edema & Pneumonia — Duration
Antecedent causes Fractured
Due to Fracture of Femur
Due to Intracranial bleeding
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Nov. 1, 1946
Major findings of operation: Fracture of frontal & temporal bone
of autopsy Same as at operation

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. McCurdy M. D.
Address Redwood & Greene Date signed 11/5/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G45275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G45275 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Delia Sewell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1872

8. AGE: Years 74 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Ignatius Sewell
13. Birthplace St. Mary's Co. Md.

MOTHER 14. Maiden Name Rebecca ??
15. Birthplace Maryland

16 (a) Informant Clonia M. Williams
(b) Address 1506 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Chas. George W. Stallings
(b) Address 1946 Druid Hill Ave.

19 (a) NOV 6 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 2 1946, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Nov 2 1946 and that I last saw h alive on Nov 1 1946

Immediate cause of death (a) Coronary Thrombosis

Due to (b) Hypertension & Arteriosclerosis

Due to (c) Neoplasm

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Saunders M. D.

Address 1214 W Lee St Date signed 11/5/46

VS 150

G45276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G45276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1902 W Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ellen M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1883

8. AGE: Years 63 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Byrd
13. Birthplace South Carolina

MOTHER
14. Maiden Name Nancy Martin
15. Birthplace South Carolina

16 (a) Informant Mrs. Ellen M. Byrd
(b) Address 1902 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Holland
(b) Address 609 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1946, at 1:57 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to Hypertension Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelpel M.D.
Medical Examiner.
Date signed 3 Nov 46

VS 181

G45277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G45277

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1860 Kelly Town Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: E. J. Daniels

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 29, 1892

8. AGE: Years 54 Months 5 Days 7 If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lee Simmons
13. Birthplace North Carolina

MOTHER
14. Maiden Name Anna Pruce
15. Birthplace North Carolina

16 (a) Informant E. J. Daniels
(b) Address 1860 Kelly Town Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)

(c) Cemetery or crematory
Location Apex, N. C.

18 (a) Funeral director John A Connelly.
(b) Address 418 Eastern Ave. Essex

19 (a) NOV 6 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1946. to Nov. 4 1946. and that I last saw he/she alive on Nov. 4 1946.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Cardiac Decompensation	3 months
Due to Hypertensive Heart Disease	1 "
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Thomas H. Cannon M. D.
Address Mercy Hospital Date signed 11-4-46

G45278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G45278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Washington Blvd (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Henry Ganz

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-09-4398

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1868

8. AGE: Years 78 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Ornamental smith

11. Industry or business Foundry Ironwork

FATHER
12. Name John Ganz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Carrie Ganz
(b) Address 1112 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery Western
Location Balto. Md.

18 (a) Funeral director William J. Ogle Son
(b) Address 1217 Park St

19 (a) NOV 6 1946 (Date rec'd by registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1946, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19__ to 19__ and that I last saw h__ alive on 19__

Immediate cause of death: Coronary Thrombosis

Due to: Myocardiolysis, Chronic

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 1 hr. Gyrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Uelrich, Jr
Address 122 Wash Blv Date signed 11/5/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G45279 Registered No.

Correct age if especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 L
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Polk Barton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Ross Barton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1873

8. AGE: Years 73 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Sykesville Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Truston Polk
13. Birthplace Delaware

MOTHER
14. Maiden Name Louisa Dorsey
15. Birthplace Ellicott City Md.

16 (a) Informant Mr. Sterett W. Polk
(b) Address 702 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory Springfield
Location Sykesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 6 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1946, at 11 39 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2, 1946 to Nov. 4, 1946 and that I last saw her alive on Nov. 4, 1946:

Immediate cause of death: Carcinoma of the Stomach — Duration: 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: none

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank H. Ogden M. D.
Address 2701 N. Calvert St. Date signed Nov. 4/46

Registered Nov 6 1946 Hugh Williams, M.D.

VS 150

G45280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G45280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital. 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Old York Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND BRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-9921

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	Married

6 (b) Name of husband/wife: (Mabel) Bright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1903

8. AGE: Years	Months	Days	If less than one day
43 43	4	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Steam Fitter
11. Industry or business Building

FATHER
12. Name Nathaniel Bright
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Layden
15. Birthplace Balto. Md.

16 (a) Informant William Bright
(b) Address 946 Abbott Court

17 (a) Burial (b) Date thereof 11/8/46
(Burial, ~~cremation, removal~~) (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 8 1946 Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1946, at 12.55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/4/46

X

G45281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G45281 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.,
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Linden Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Guy Vane

3 (b) If veteran, name war:

3 (c) Social Security Account No. 216-112-2367

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Estelle Vane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1866

8. AGE: Years	Months	Days	If less than one day
80	7	29	hr. min.

9. Birthplace Church Creek, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Geo. Kirby Paint Mfg. Co.

FATHER
12. Name William A. Vane
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Sarah Pattison Fooks
15. Birthplace Md.

16 (a) Informant Mr. Floyd B. Vane, Sr.
(b) Address 2544 Arunah Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-46 (month) (day) (year)
(c) Cemetery or crematory Old Trinity
Location Church Creek, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (Filed) NOV 6 1946 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION 9.15

20. DATE OF DEATH November 4, 1946, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1946, to Nov 4 1946, and that I last saw h alive on Aug 3 1946.

Immediate cause of death ~~Acute Uremia~~ Carcinoma of Prostate

Duration one year

Due to metastasis to Liver & Lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.

Address 1939 Edmondson Ave Date signed Nov 5-46

X

JL G45282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G45282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 11 - 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. ? 1864

8. AGE: Years 81 82 ? Months ? 11 Days ? If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Shaw
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) NOV 6 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1946 19 , at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13-44 19 , to Nov. 5 19 46, and that I last saw h alive on Nov 5 1946

Immediate cause of death: Hypertension C.V.D. — Duration 5 yrs

Due to

Due to

Other Conditions Spinal Cord tumor — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. Russell Huff M. D.
Address Baltimore City Hosp. Date signed 11-6-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Gaithersburg, Md.

937

G45283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G45283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 N. Parrish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N Parrish St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillie Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Brown

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank B. Marshall

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) March 6, 1906

8. AGE: Years 40 | Months 9 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Caswell Co. N. C.
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Andrew Everett
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ida Mitchell Everett
15. Birthplace North Carolina

16 (a) Informant Mrs Idabelle Ferguson
(b) Address Box 234 Northside W. Va

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Danville Va.
Location

18 (a) Funeral director Mrs Katie L. Williams
(b) Address 322 N. Eutaw St.

19 (a) NOV 6 1946 (b) Registrar
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1946, at 11:00 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1946 to 11/2 1946 and that I last saw h.d alive on 11/2 1946.

Immediate cause of death Cancer of left breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Sellers, M.D.

Address 601 N Calhoun St Date signed 11/4/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45284 | BALTIMORE CITY HEALTH DEPARTMENT | CERTIFICATE OF DEATH | X ✓ 94a | Registered No. G45284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St
(c) Hospital or institution: St Jos. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 8701 Raven Drive, Towson (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Victor Anthony

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Meta Mathilda Wadman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Albany, N. Y. (Town, county, and state)

10. Usual Occupation Wholesale Paint

11. Industry or business

FATHER 12. Name Victor

13. Birthplace Russia

MOTHER 14. Maiden Name Minnie

15. Birthplace Russia

16 (a) Informant Mrs. Meta M. Anthony

(b) Address 8701 Raven Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-46 (month) (day) (year)

(c) Cemetery or crematory New York, N.Y.

Location

18 (a) Funeral director Jack Deems Inc

(b) Address 1439 E. Baltimore St

19 (a) (Date received by registrar) NOV 6 1946 Huntington Public Health Officer

VS 19

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Nov. 1946, at 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions Laceration, left supra-orbital region due to fall
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 4 Nov. 1946

X

G45285 Nuth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

89a

Registered No. G45285

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine E. Nuth

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. [redacted] W

6 (b) Name of husband or wife Henry E. Nuth
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1884

8. AGE: Years	Months	Days	If less than one day
61 62	11	3	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Fallon
13. Birthplace Ireland

MOTHER
14. Maiden Name Elisabeth Conroy
15. Birthplace Ireland

16 (a) Informant H Eugene Nuth
(b) Address 3600 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 - 46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Frederick Rd

18 (a) Funeral director Joseph Kasinskas Sons
(b) Address 60 E Washington Blvd

19 (c) (Date rec'd by local registrar) NOV 8 1946 Huntington Williamson Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 7:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1946 to 11-5 1946, and that I last saw h[illegible] alive on 11-5 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Circulatory collapse	
Due to Pneumococcic meningitis	
Other Conditions Otitis media mastoiditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. May M. D.
Address Calvert & Saratoga Sts Date signed 11-5-46

X

G45286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G45286

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11m 10d
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Eva Kaubris Zelniskas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Anthony Zelnyskas

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 1873

8. AGE: Years	Months	Days	If less than one day
73	7	8	hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation tailoring

11. Industry or business

FATHER
12. Name George ?
13. Birthplace Lithuania

MOTHER
14. Maiden Name Mary Machulionis
15. Birthplace Lithuania

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8 -46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Relair Rd

18 (a) Funeral director Joseph Rasimakas Jr
(b) Address 604 Wash. Blvd

19 NOV 6 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-4- 1946, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30- 1946 to Nov 4- 1946, and that I last saw h-r alive on Nov 4- 1946.

Immediate cause of death	Duration
Edema Lungs	3 days
Due to Cerebral Hemorrhage	6 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E. North Ave Date signed 11/5/46

G45287 BALTIMORE CITY HEALTH DEPARTMENT G45287

CERTIFICATE OF DEATH 49a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RACHEAL ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: COLORED

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife JOHN W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1910

8. AGE: Years 36 | Months 7 | Days - | If less than one day hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation LAUNDRESS

11. Industry or business

FATHER 12. Name PEARLY ALDERMAN
13. Birthplace NORTH CAROLINA

MOTHER 14. Maiden Name LUCENIA THOMAS
15. Birthplace NORTH CAROLIN

16 (a) Informant: JOHN W. ROBINSON
(b) Address 2430 Madison Ave,.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof II-7-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co, Md,.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna,. Ave,.

NOV 6 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

Nov 4, 1946 MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 194 , at 6 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1946 to 11/4 1946 and that I last saw h[illegible] alive on 11/3 1946

Immediate cause of death: Cerebral Hemorrhage
Due to: Subdural
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: ?

Date of operation 9-17-46
Major findings of operation: Cerebral Hemorrhage
of autopsy: Subdural

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 1207 Cathedral Date signed 11/4/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45288 CWK-105816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G45288 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 44- 1- 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 843 S. Kenwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Kowalewski or Stanisleus Kowalewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 222-05-8728

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1-1902

8. AGE: Years	Months	Days	If less than one day
44	1	4	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kowalewski
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 S Ann st

19 (a) (Date rec'd by registrar) (b) Burlington Williams Registrar

NOV 9 1946

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH November 5 1946 at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1946 to Nov. 5 1946, and that I last saw him alive on Nov. 5 1946.

Immediate cause of death Circulatory failure — Duration

Due to Hypertensive C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Enlarged fatty heart, Hemorrhagic lungs

of autopsy: Enlarged heart, Hemorrhagic lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address C.C.H. Date signed 11/8/46

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G45289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G45289 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Bolton St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Bolton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Risteau Grason

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Florence Brown
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1875

8. AGE: Years	Months	Days	If less than one day
70	11	14 13	hr. ___ min.

9. Birthplace Towson, Md. (Town, county, and state)
10. Usual Occupation lawyer -- retired 25 yrs.
11. Industry or business

FATHER
12. Name John Grayson
13. Birthplace Md.

MOTHER
14. Maiden Name Ida May Brown
15. Birthplace Md.

16 (a) Informant Mrs. Florence B. Grason
(b) Address 1412 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1500 Eutaw Place

19 (a) NOV 6 1946 (Date rec'd by registrar) Huntington Willis [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1946 19 , at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to Nov 3 1946 and that I last saw alive on Nov 3 1946

Immediate cause of death: Coronary Thrombosis — Duration 2 hrs
Due to Arterio-Sclerosis — Gradual
Due to Hypocardelia — "
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W A Ready M.D.
Address 1403 Park Ave. Date signed 11/5/46

VS 150

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G45290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

G45290 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1227 Linden Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 Linden Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Warner Pennington ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1864

8. AGE: Years	Months	Days	If less than one day
82	2	13	hr. min.

9. Birthplace Cecil County, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Andrew J. Pennington
13. Birthplace Cecil County, Md.

MOTHER
14. Maiden Name Ann Jane Rice
15. Birthplace Wilmington, Del.

16 (a) Informant Mr. Laurie H. Riggs
(b) Address Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 6 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1946, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1917 to Nov 5 1946 and that I last saw h[er] alive on Nov 5 1946

Immediate cause of death: Labor Pneumonia
Due to: Pneumonia central hemorrhage — in the last 3 hrs
Due to: Hypertension
Other Conditions: Cardiac hypertrophy, auricular fibrillation
(Include pregnancy within 3 months of death)

Duration: 3 days / 3 yrs / 3 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify typeof place)
(e) Means of injury

23. Signature John C Luntzhar M. D.
Address 12 E. Eager St. Date signed Nov 6/46

VS 150

Luntzhar ✓

G45291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G45291 Registered No.

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 8 W 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 E. Preston St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jackson Mary Marcus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Nelson Marcus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/2/03

8. AGE: Years 43 | Months 9 | Days 1 | If less than one day: hr. min.

9. Birthplace Midland, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Calvin Jackson
13. Birthplace Va

MOTHER: 14. Maiden Name Margaret Taylor
15. Birthplace Va.

16 (a) Informant Nelson Marcus
(b) Address 1743 E. Preston St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory
Location Midland, Va.

18 (a) Funeral director Joseph C. Locke
(b) Address 1364 N. Central Ave

19 (a) NOV 6 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1946 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1946 to 11/3 1946, and that I last saw h[illegible] alive on 11/3, 1946.

Immediate cause of death Chronic Passive Congestion of Lungs. | Duration 5 yrs. (2)

Due to Hypertensive Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Provident Hosp. Date signed 11/7/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

G45292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

118

G45292 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E Reed
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Agnes M. Reed
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 24, 1888

8. AGE: Years	Months	Days	If less than one day
58	3	9	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name George W. Reed
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Hunter
15. Birthplace Pennsylvania

16 (a) Informant Anna E White
(b) Address 1003 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd

18 (a) Funeral director John F Neyen Son
(b) Address 716 Light St.

19 (a) NOV 6 1946 (Date) registered) by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Novemb 3 1946 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1946 to Nov 3 1946, and that I last saw h alive on Nov 3 1946.

Immediate cause of death Shock due
Chronic dilatation of stomach
Due to Pyloric Obstruction
Due to Adhesions + acute angulation.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Dr. Did. Ostrand

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Bowers
Address So. Balt. Gen. Hosp. Date signed 11/4/46

VS 150

7 O Carrickson X

G45293 — BALTIMORE CITY HEALTH DEPARTMENT — G45293

CERTIFICATE OF DEATH 194a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 S Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Earl Grant

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-7168

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife J. Elsie Barrow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1895

8. AGE: Years	Months	Days	If less than one day
51	8	10	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Pipe Fitters Helper

11. Industry or business U.S. Coast Guard

FATHER
12. Name Acey F. Grant
13. Birthplace Georgia

MOTHER
14. Maiden Name Alice Johns
15. Birthplace So. Carolina

16 (a) Informant Family
(b) Address 1732 S. Charles St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie

18 (a) Funeral director L. Du Early.
(b) Address 130 S. Fort Ave.

19 (a) NOV 6 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 19 46 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.
Date signed 3 Nov 46

G45294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 172

G45294 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Key Highway
(c) Hospital or institution: Bethlehem Steel Clinic 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826- S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mattie Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1920

8. AGE: Years 26 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace Augusta Georgia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Clonnie Jackson
13. Birthplace Georgia

MOTHER
14. Maiden Name Georgia Ross
15. Birthplace S.C.

16 (a) Informant Mattie Jackson (W)
(b) Address 826 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-46 (month) (day) (year)
(c) Cemetery or crematory Balto National Cy
Location Balto City

18 (a) Funeral director Isaiah J. Brown Sons
(b) Address 1980 W Montgomery St

19 (a) (Date rec'd by registrar) NOV 8 1946 (b) Lucien Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946 at 11.50 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/2

(a) Date of injury 11-1-46 11.40 a.M.
(b) Where did injury occur? (Graving dock) 1101 Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell to dock when life boat overturned. dock.

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 11-1-46

G45295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G45295 Registered No.

Write the causes of death clearly and legibly. Physicians: please write to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2576 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2572 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Ford

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Martha E. Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1867

8. AGE: Years	Months	Days	If less than one day
78	10	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name James R. Ford
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katherine Campbell
15. Birthplace Balto. Md.

16 (a) Informant Martha Ford
(b) Address 2572 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Philip Keiser's Sons
(b) Address 2024 Orleans St.

19 (a) (Signature of registrar) (b) Registrar
Nov 9 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5th. 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946 to 11-5- 1946, and that I last saw him alive on 10-25-46

Immediate cause of death	Duration
arteriosclerotic heart disease	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ware & Lembel, M.D.
Address 2703 Edmondson Ave. Date signed 11-6-46

G45296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45296

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1326 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUISA WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1871

8. AGE: Years	Months	Days	If less than one day
75	8	9	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy Ward
15. Birthplace Md.

16 (a) Informant Mrs. Anna Coleman
(b) Address 1326 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-46 (month) (day) (year)
(c) Cemetery or crematory St. Lukes Cem
Location Hereford, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
Filed by registrar Nov 8 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1946 at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1946 to 11-4 1946 and that I last saw h alive on 11-4 1946

Immediate cause of death Myocardial Degeneration — Duration —

Due to

Due to

Other Conditions Hypertension and Heart Disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1343 Penna. Ave Date signed 11-7-46

VS 150

G45297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G45297

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 N. Carey St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: GEORGE H. MURRAY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Eliza Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1890

8. AGE: Years	Months	Days	If less than one day
55	11	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Motor Truck Operator
11. Industry or business

FATHER
12. Name Dave Murray
13. Birthplace Va.

MOTHER
14. Maiden Name Not Known
15. Birthplace Va.

16 (a) Informant Mrs. Eliza Murray
(b) Address 243 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) (b) Registrar

NOV 6 1946

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH November 4, 1946 at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1946 to Nov. 4 1946. and that I last saw him alive on Nov. 2 1946.

Immediate cause of death — Duration
Lung abscess — 6 mos
Myocardial degeneration — ?
Hypertension — ?

Other conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Wallis Pennington M. D.
Address 201 N Carey Date signed 11/8/46

G45298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G45298 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 Holbrook Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Holbrook Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gregor J. Guenther

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-01-2370

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara M. Fangmann
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1898

8. AGE: Years	Months	Days	If less than one day
47	10	12	###### min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Ship joinger
11. Industry or business Coast Guards

MOTHER / FATHER
12. Name John Guenther
13. Birthplace Germany
14. Maiden Name Magdalena Mennuger
15. Birthplace Germany

16 (a) Informant Mrs. Clara M. Guenther
(b) Address 1403 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received by registrar) (b) Registrar

VS 150 NOV 6 1946 Huntington Hillsboro, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 19 46 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 19 46, to Nov 4 1946 and that I last saw h[illegible] alive on Nov 2 19 46.

Immediate cause of death: Carcinoma Stomach

Duration

Due to
Due to
Other conditions Myocardial. Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Scheuprle
Address 1337 S. Clarke St. Date signed 11/7/46

X

G45299 Bf. J. 61059 BALTIMORE CITY HEALTH DEPARTMENT G45299

CERTIFICATE OF DEATH √161a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Maria Danell Long

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31 1946

8. AGE: Years	Months	Days	If less than one day
		6 5	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Long
13. Birthplace Balto Md

MOTHER
14. Maiden Name Stella Bernadine Mateyak
15. Birthplace Balto Md.

16 (a) Informant Mother
(b) Address 2700 Hudson St Bald md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto County

18 (a) Funeral director John M. Wilbur
(b) Address 401 S. Chester street

19 (a) (Date received by registrar) (b) Huntington Williams Md

NOV 6 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Nov (month) (day) 1946 at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Oct 1946 to 5 Nov 1946, and that I last saw h.e.r alive on 5 Nov 1946.

Immediate cause of death: atelectasis (26 weeks gestation) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Wilson, Jr
Address St. Joseph's Hospital Date signed 5 Nov 46 M. D.

X

G45309 79628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

Registered No. G45300

Write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto - (If outside city or town limits, write RURAL and give town)
(d) Street No. 1441 Parish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estalls Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	married

6 (b) Name of husband or wife Sylvester Robinson
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 8/26/90

8. AGE: Years	Months	Days	If less than one day
56 55	2	9	hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Rogers
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Johnson
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4. 46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore City
18 (a) Funeral director Geo G Kelson
(b) Address 303 Presstman St
19 (a) (Delivered to) (Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1946 at 9.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1946 to Nov 4 1946 and that I last saw her alive on Nov. 4 1946.

Immediate cause of death Pneumonia

Duration

Due to Pulmonary edema - anasarca - goiter — 3 days

Due to Congestive pantocellular cirrhosis of liver — 21 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Gastro Oct 22 46 Oct 24 46

Major findings of operation: 1 Goiter

of autopsy: Liver Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W Hunter Long M. D.
Address The Johns Hopkins Hosp Date signed 11/5/46

VS 150

X

G45301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1276 Registered No. G45301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404 S. Robinson St.
(c) Hospital or institution: West Bal Gen. Hosp.
(d) Length of stay in hospital or inst. (~~year, month, or~~ days) 34
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26-1870

8. AGE: Years 76 | Months - | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name UNKOWN
13. Birthplace —

MOTHER
14. Maiden Name UNKOWN
15. Birthplace

16 (a) Informant John J. Sanders (Son)
(b) Address 215 S. Elwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Dundalk

18 (a) Funeral director Lilly & Zielke Inc
(b) Address 403 S. Wolfe St.

19 (a) NOV 6 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 4:37 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1946, to 11-5-46 1946, and that I last saw h alive on 11-4- 1946.

Immediate cause of death Coronary artery Heart Disease — Duration

Due to Hypertensive C-V Heart Disease.

Due to Arteriosclerosis

Other Conditions Post Operative Cholecystectomy.
(Include pregnancy within 3 months of death)

Date of operation 10-8-46

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry T. Zinger M. D.
Address West Baltimore Gen. Hosp. Date signed 11-5-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

G45302

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G45302 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3828 LEO ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town EAST BROOKLYN (If outside city or town limits, write RURAL and give town)
(d) Street No. 3719 LEO ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM J COYNE

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-4614

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ELIZABETH COYNE
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) OCT 10 1882

8. AGE: Years 64 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business EASTERN BOX Co

FATHER
12. Name MICHAEL COYNE
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY MURPHY
15. Birthplace BALTIMORE MD

16 (a) Informant ELIZABETH COYNE
(b) Address 3719 LEO ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 8-46 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A-A Co.

18 (a) Funeral director Bernard E Hank
(b) Address 121 E West St

NOV 6 1946 (b) (Date rec'd by registrar) Registrar for Williamsburg District

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 5th 1946, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1943 to NOV 5 1946, and that I last saw h. alive on NOV 5 1946.

Immediate cause of death	Duration
Arteria-Sclerotic Cardio-Vascular Disease	3 yrs
Due to Cardiac Hypertrophy	
Due to Cardiac Decompensation	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 920 Patapsco Ave Date signed 11/5/46 M. D.

X

G45303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

457

G45303 Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County Delta Mich Co.
(c) City or town Manistique
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jensen, William Christopher

3 (b) If veteran, name war

3 (c) Social Security Account No. 385-18-1657

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Fay Fauben Jensen
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 3, 1904

8. AGE: Years	Months	Days	If less than one day
42	8	2	hr. min.

9. Birthplace Beaver Island, Mich.
(Town, county, and state)
10. Usual Occupation Ordinary Seaman
11. Industry or business Seafarer

FATHER
12. Name Nils Peter Jensen
13. Birthplace Denmark

MOTHER
14. Maiden Name Julia Waltcher
15. Birthplace Michigan

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 6-46 (month) (day) (year)
(c) Cemetery or crematory
Location Manistique Mich

18 (a) Funeral director Leo J. Berger Jr
(b) Address 1512 Hollins St.

19 NOV 6 1946 (Date rec'd by Registrar) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 8:10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946 to Nov. 5 1946, and that I last saw him alive on Nov. 5 1946.

Immediate cause of death Pulmonary embolus — Duration 30 min.

Due to

Due to

Other Conditions Carcinoma of left mandible & left neck with metastasis to cervical nodes, left. — 4 yrs.
(Interval between onset and death)

Date of operation 11-5-46

Major findings of operation: Metastasis, anterior cervical nodes & carotid bulb region.

of autopsy None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/6/46

G45304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

G45304 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 N.Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N.Fulton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE BOSTON ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C	Married

6 (b) Name of husband or wife Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/1899

8. AGE: Years	Months	Days	If less than one day
47	0	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Johnson
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Pearl Hill (Daughter)
(b) Address 528 N.Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. County Md.

18 (a) Funeral director Charles G.Cooper
(b) Address 510-512 N.Carrollton Ave

19 (a) NOV 6 1946 (b) Registered by registrar

Huntington Hillsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd 1946 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Nov 2 1946 and that I last saw h[illegible] alive on 11/2 1946.

Immediate cause (a) Congestive C.H.F.
(b) Arteriosclerosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 Month

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. N. Statler
Address 1115 Pa Ave Date signed 11/6/46

VS 150

X

5305 BALTIMORE CITY HEALTH DEPARTMENT G45305
CERTIFICATE OF DEATH 131a Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 - School St
(c) Hospital or institution:
1571
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 - School St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Brown
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Eliza Mae Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months 69 | Days | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Joseph Brown
(b) Address 5714 W. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 7 (day) 46 (year)
(c) Cemetery or crematory Cathedral
Location Md.

18 (a) Funeral director Mrs. G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) NOV 6 1946 (Date rec'd by registrar) (b) Washington Williams III Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1946 to 11-4-1946 and that I last saw him alive on 11-2-1946.

Immediate cause of death	Duration
Chronic Cardiovascular Renal disease	
Due to Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. C. Jackson
Address 608 N Arlington Ave Date signed 11/6/46

VS 150

G45306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 W. West St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-12-999

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife James E. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1903

8. AGE: Years	Months	Days	If less than one day
43	-		hr. min.

9. Birthplace Va.
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas Jefferson
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant James E. Johnson
(b) Address 121 W. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location

18 (a) Funeral director Joseph L. Young
(b) Address 2262 N. Carrollton Ave

19 (a) NOV 8 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1946, at 5:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis
Degeneration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Schleicher M.D.
Medical Examiner.
Date signed 11/7/46

X

G45307

CHK-107065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X/65a

G45307

Registered No.

Write the causes of death clearly and legibly. Physicians: please write if your sig is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 33- 4- 4-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ~~Baltimore~~ Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Main Ave. Catonsville (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1911

8. AGE: Years	Months	Days	If less than one day
35	4	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Cornelius (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Josephine Cross
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-46 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville Md.

18 (a) Funeral director F.C.Hiob Inc Thom
(b) Address Ellicott City Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1946, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946, to Nov. 5 1946, and that I last saw him alive on Nov. 5 1946.

Immediate cause of death Addison's Disease — Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Greatly enlarged adrenals

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J S Bord M. D.
Address Balto City Hosp Date signed 11-5-46

VS 150

Not to be signed by Washington Williams, M.D.

G45308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G45308 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St
(c) Hospital or institution Hospital for Women of Md 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Appleby Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Irene Blanch Wheeler

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William C Wheeler

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) June 6, 1904

8. AGE: Years 42 | Months 4 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Harvey Alexander
13. Birthplace Maryland

MOTHER
14. Maiden Name Lida Faye Alexander
15. Birthplace Maryland

16 (a) Informant Husband of deceased
(b) Address 1319 Appleby Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Lehnguth & Donovan
(b) Address 2615-17 Liberty Heights Ave

19 (a) ____ (Date rec'd by registrar) (b) Filed for record Nov 7 1946 Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1946, at 11 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1946, to ____ 19__, and that I last saw h&W alive on Nov 4 1946.

Immediate cause of death Cerebro-vascular accident — Duration

Due to Hypertensive cardiovascular disease

Due to ____

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: ____

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. H. Logan M. D.
Address Hosp for Women of Md Date signed 11/5/46

X

G45309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45309 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Denling Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Denling Court. Denmeling
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Daubert.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25 1884

8. AGE: Years	Months	Days	If less than one day
62	9	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business Southern High

FATHER 12. Name Frank Dorbert

13. Birthplace Germany

MOTHER 14. Maiden Name Kunigunda Heim

15. Birthplace Germany

16 (a) Informant Frank Dorbert

(b) Address 610 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Catf

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2108 Orleans St

19 (a) (Date rec'd by registrar) NOV 6 1946 (b) Registrar Huntington Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1946, at 11 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio. vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Thomas J. Mussen M.D.
Medical Examiner.

Date signed 11-4-46

X

G45310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G45310
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument + Rutland Aves
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H Beppler

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-05-6903

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Merle B Beppler
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Sept 2-1901

8. AGE: Years	Months	Days	If less than one day
45	2	4	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Machinist
11. Industry or business Machine Shop

FATHER
12. Name Charles W Beppler
13. Birthplace Md

MOTHER
14. Maiden Name Annie H Lingenman
15. Birthplace Md

16 (a) Informant Mrs Merle Beppler
(b) Address 1510 Hollins St

17 (a) Burial (b) Date thereof Nov 9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill Cem
Location Pleasant Hill Md

18 (a) Funeral director Geo L Keeyer Jr
(b) Address 1512 Hollins St

19 (a) NOV 6 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/46, 19 , at 6 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1946, to Nov 6 1946 and that I last saw h — alive on Nov 6 1946.

Immediate cause of death Cardiac Failure — Duration

Due to Coronary sclerosis — —

Due to Old myocardial infarct — —

Other Conditions — —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sam Rabb M. D.
Address Sinai Hosp Date signed 11/6/46

VS 150

G45311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G45311 Registered No.

Please write the cause of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 S. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Prince George Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace "

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Nelson Ward

(b) Address 610 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Elroy A. Wilson

(b) Address 1000 Brantly Ave

19 NOV 7 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 — 1946. I A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1946. to 11/3 1946. and that I last saw h— alive on 11/3

Immediate cause of death Coton Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Rhetta M. D.

Address 134 Dunbar Rd Date signed 11/7/46

VS 150

G45312 105828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45312 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 475, White Marsh, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecil Nickle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1883

8. AGE: Years	Months	Days	If less than one day
62	8	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Nickle
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Shore
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-46 (month) (day) (year)
(c) Cemetery or crematory Oxford, Chesco Pa.
Location Oxford Pa.

18 (a) Funeral director C. P. Rogers
(b) Address Oxford Pa.

19 (a) NOV 3 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1946, at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1946 to Nov. 6 1946, and that I last saw him alive on Nov 6th 1946

Immediate cause of death	Duration
Subacute bacterial endocarditis.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Typical Path.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Doyle Waldron M. D.
Address B. C. H. Date signed 11/6/46

5313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
(1937)

Registered No. C 5313

please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-14-46 to 11/6/46
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Fourth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mallie Tracey

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1868

8. AGE: Years	Months	Days	If less than one day
78	9	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name William Throop
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Milton Tracey
(b) Address 24 Monor Ave

17 (a) Burial (b) Date thereof 11/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) NOV 7 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1946 at 7 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/46 1946 to 11-6 1946 and that I last saw her alive on 11-6 1946.

Immediate cause of death: Respiratory failure
Due to: Cerebral hemorrhage
Due to: Arteriosclerotic C.V.D.
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. May
Address Calvert & Saratoga Sts. Date signed 11-6-46 M. D.

VS 150

G45314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G45314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 771 Dover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Florence Chase

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace A-A. Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Florence
(b) Address 771 Dover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 1142 W Fayette St

19 (a) [illegible] (b) [illegible] Williamsport Md

NOV 7 1946

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1946 at 7 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.e death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. V. Kubricht M.D.
Medical Examiner.
Date signed 11/6/46

G45315 BALTIMORE CITY HEALTH DEPARTMENT G45315
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT E. COUGHLAN
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 213-05-4912 B
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced Divorced
6 (b) Name of husband or wife Enid Chalf
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 5 1875
8. AGE: Years 71 Months 2 Days 0 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business
FATHER 12. Name Coughlan
13. Birthplace Baltimore Md
MOTHER 14. Maiden Name Eliza Robinson
15. Birthplace Md
16 (a) Informant Robt E Coughlan Jr
(b) Address 901 W. University Pkwy
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 7 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md
18 (a) Funeral director Henry W. Jenkins Inc
(b) Address 711 Cathedral Street
19 (a) NOV 7 1946 (Date rec'd by registrar) (b) [signature] for Williams M.D. Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 11/5/46 19 , at 8:45 A M
21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH
(a) Coronary Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature John R. Davis M.D. Medical Examiner.
Date signed 11/5/46

VS 151

G45316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G45316 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2662 Oswego Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2662 Oswego Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Kaplan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Wolf Silberglit
13. Birthplace Russia

MOTHER
14. Maiden Name Martha ?
15. Birthplace Russia

16 (a) Informant Mr Nathan Kaplan
(b) Address 2662 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Filed (State and by authority) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1946, at 12.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to Nov 6 1946, and that I last saw her alive on Nov 6 1946.

Immediate cause of death Carcinoma of Esophagus — Duration Cause

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Kaplan
Address 2904 Reisterstown Rd Date signed 11/7/46

VS 150

G45317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G45317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2525- Boarman Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2525- Boarman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Fulcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Glover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15th. 1921

8. AGE: Years	Months	Days	If less than one day
25	8	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife.

FATHER
12. Name Morris Bloom
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sadie Litriv
15. Birthplace Russia

16 (a) Informant Morris Bloom
(b) Address 2525- Boarman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem.
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1946, at 9.45 a M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Asphyxiation
Due to Hanging

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-6-46 9. 10 a. M.
(b) Where did injury occur? 2525- Boarman Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Found hanging in cellar- by clothes line from rafter

23. Signature Howard J. Kincaid M.D. Medical Examiner.
Date signed 11-6-46

6

X

G45318

378012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G45318
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Coral Gables (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Toledo St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian McCall

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edward B Call
6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.) 5-29-72

8. AGE: Years 74 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Housef.
11. Industry or business

FATHER
12. Name Eli Thomas
13. Birthplace Pa.

MOTHER
14. Maiden Name Katherine Alles
15. Birthplace Pa.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9/46 (month) (day) (year)
(c) Cemetery or crematory
Location Coral Gables Fla.

18 (a) Funeral directors John D. Mitchell & Sons
(b) Address 1908 Eutaw Place

19 (a) (Signature of registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946 at 12 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18- 1946, to 11-6- 1946, and that I last saw h. alive on 11-6- 1946.

Immediate cause of death: Lymphosarcoma — Duration: 9 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice B Wintrobe
Address J H Hospital Date signed 6 Nov 46 M. D.

VS 150

G45319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Registered No. G45319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 Rosebank Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Rosebank Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE T. HOLMES

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas H. Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1865

8. AGE: Years	Months	Days	If less than one day
81	5	3	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick McDonald
13. Birthplace Ireland

MOTHER
14. Maiden Name - Betts
15. Birthplace Maryland

16 (a) Informant Mr. Richard B. Holmes, grandson
(b) Address 410 Rosebank Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by registrar) Registrar

NOV 7 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1946 to Nov 4 1946, and that I last saw h[illegible] alive on Nov 4 1946.

Immediate cause of death	Duration
Chron Myocarditis	1940
Due to Obstruction Intestine Nephritis	1943
Due to	
Other Conditions Bronchpneumonia	1946

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Bishop M. D.
Address 912 Kenda C Date signed Nov 4-1946

X

G45320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

G45320 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Stanford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 5, 1873
8. AGE: Years 73 Months - Days 29 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Adams
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Braces
15. Birthplace Maryland

16 (a) Informant Lawrence T. Stiles
(b) Address 521 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. M. Holland
(b) Address 1621 Druid Hill Ave.

19 (a) (Signature of city registrar) (b) Huntington Williams, Registrar
NOV 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1946, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946, to Nov. 4 1946, and that I last saw h alive on Nov. 4 1946.

Immediate cause of death: Cerebral Embolism

Duration: 9

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature CHARLES T. WIGGLAND M. D.
Address 521 Robert St. Date signed 11-5-46

X

G45321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No. G45321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE.
(c) Hospital or institution:
CONVALESENCE HOME 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8YEARS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5616 BENTON HEIGHT.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. PENNELL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James Pennell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1870

8. AGE: Years 76 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Paul C. Brown

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Decker

15. Birthplace Germany

16 (a) Informant Mrs Anna Miller

(b) Address 5615 Benton Heights Ave

17 (a) Balto Cem (b) Date thereof Nov 8 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) Filed by registrar NOV 7 1946 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION P

20. DATE OF DEATH NOV 4 1946 19 at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 2 1946 to NOV 4 1946 and that I last saw h er alive on NOV 4 19 46

Immediate cause of death		Duration
APOPLEXY	NOV 4	1946.
Due to CHRONIC MYOCARDITIS		1946
Due to ARTERIOR SCLEROSIS		1946.
Other Conditions CHRONIC ARTHRITIS 1938. (Include pregnancy within three months of death)		

Date of operation NONE

Major findings of operations: NONE

of autopsy: NO

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas S Coleman

Address 3013 ST PAUL STREET Date signed NOVEMBER 5 1946

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

G45322 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NJ (b) County
(c) City or town Merchantville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Chapel Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson, John Henry

3 (b) If veteran, name war
3 (c) Social Security Account No. 716-05-4103

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louressa Broadwater
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Mar. 3, 1884
8. AGE: Years 62 | Months 8 | Days 3 | If less than one day hr. min.
9. Birthplace Frederica, Del. (Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Seafarer

FATHER
12. Name Harry Wilson
13. Birthplace Chester, Del.

MOTHER
14. Maiden Name Mary Marker
15. Birthplace Smyrna Del.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/7/46 (month) (day) (year)
(c) Cemetery or crematory Colestown
Location Merchantville, N. J.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 7 1946 (Date filed by registrar) Huntington Williams, M.D. (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1946, at 3:50P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1946, to Nov. 6 1946, and that I last saw him alive on Nov. 6 1946.

Immediate cause of death: Malignant neoplasm, type undetermined, wall of urinary bladder causing bi-
Due to: lateral hydronephrosis and uremia
Due to:

Other Conditions: Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

Duration: UNKNOWN

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/7/46

G45323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G45323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 N. KRESSON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM E. LIBKEY

3 (b) If veteran, name war: War 1

3 (c) Social Security Account No. 213-03-9186

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Clara

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 6-6-97

8. AGE: Years	Months	Days	If less than one day
49	5	1	hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business S.K Meat Packers

FATHER:
12. Name John Henry Libkey
13. Birthplace Basto

MOTHER:
14. Maiden Name Mary Ann Flynn
15. Birthplace Basto

16 (a) Informant Clara Libkey
(b) Address 43 N. Krasson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 9 46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Garrison Hill Rd

18 (a) Funeral director Marsh W.E. Dippel Sons
(b) Address 37 S. Ann St.

19 (a) NOV 7 1946 Registered by registrar Barrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-46 19 at 12:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6- 1946 to 11-7 1946 and that I last saw him alive on 11-6 1946

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cardiac decompensation	
Due to Myocardial degeneration due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John S. Stevens

Address 31 S. Ann St Date signed 11/7/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G45324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G45324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4802 Althea Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4802 Althea Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

26 - 2

3 (a) FULL NAME David H. Keating

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1858

8. AGE: Years	Months	Days	If less than one day
88	2	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Carrige Builder
11. Industry or business Retired

FATHER
12. Name John P. Keating
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Willis C. Keating
(b) Address 4804 Althea Ave.

17 (a) Burial (b) Date thereof 11/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 7 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/46 19 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946, to Nov 5 1946, and that I last saw him alive on Nov 5 1946.

Immediate cause of death

	Duration
Cerebral Hemorrage	10 hrs
Due to Chr. Myocarditis	1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Brown M. D.
Address 1663 W. North Ave. Date signed 11/6/46

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G45325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G45325
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 MARECO. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 MARECO Ave
(If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. (Brown) Parks

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Alfred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22 (1877)

8. AGE: Years 76 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Marie Leyh
(b) Address 3110 Mareco Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9-46 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Westminster

18 (a) Funeral director Joseph Ragan & Son
(b) Address 60 E. Wash. Blvd.

NOV 7 1946 (a) Date rec'd by registrar Huntington Williams, M.D. (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Nov. 5 1946, and that I last saw her alive on Nov. 5 1946.

Immediate cause of death — Duration
Acute Cardiac decompensation.
Due to Arteriosclerotic Cardio-vascular disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. B. Stevens M.D.
Address 3700 Eastern Ave Date signed 11/5/46

Write the causes of death clearly and legibly. Physicians: please write correctly as especially important.

VS 150

G45326 Hospital Disposal Hosp 52036

BALTIMORE CITY HEALTH DEPARTMENT

TN. 104867

CERTIFICATE OF DEATH

1192 ✓

Registered No. G45326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Homewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Bothne (Beverley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28/1946

8. AGE: Years	Months	Days	If less than one day
		28	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Bothne
13. Birthplace ?

MOTHER
14. Maiden Name Beverley Howde
15. Birthplace New York

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11/1/46 (month) (day) (year)
(c) Name of crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

19 (a) NOV 7 1946 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26/46 19 , at 8.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28/ 1946 to Oct 26/ 1946 and that I last saw her alive on Oct 26/ 1946

Immediate cause of death Malnutrition, dehydration, sepsis — Duration 2 wks 4 days

Due to diarrhea — Duration 3 wks

Due to Prematurity — Duration Life

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo Leon E. Hughes M.D.
Address Balto City Hosp Date signed Oct 31 46

VS 150

Correct age if necessary. Important! Physician: please write the causes of death clearly and legibly.

X

G45327

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

G45327 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ALVIN WESTCOTT

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 2-1937

8. AGE: Years	Months	Days	If less than one day
9	2	3	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Schoolboy

11. Industry or business

FATHER 12. Name Harold M. Westcott

13. Birthplace Virginia

MOTHER 14. Maiden Name Anna M. Allen

15. Birthplace Maryland

16 (a) Informant Elwood J. Westcott

(b) Address 605 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-46 (month) (day) (year)

(c) Cemetery or crematory Govans Presbyterian

Location Balto. Md.

18 (a) Funeral director Thomas J. Kenny Inc.

(b) Address Hollins & Gilmor

19 (a) (b)

Date rec'd by registrar NOV 7 1946 Registrar Huntington Williams, M.D.

OS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Crushed Head.

Multiple Fractures

Due to Internal Hemorrhage

Other Conditions: Lacerations & bruised brain

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-5-46 at 5:00 P.M. 1914

(b) Where did injury occur? Lombard & Gilmor Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian Struck by auto

23. Signature Howard J. Madeira M.D. Medical Examiner.

Date signed 11-6-46

G45328 41842 fuer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G45328 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town Charleston (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 423 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Olga Jasch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-46

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Ind. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name —
13. Birthplace

MOTHER 14. Maiden Name Olga Jasch
15. Birthplace Records

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Body disposed by hospital
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 7 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1946 at 2.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1946 to Oct 29 1946 and that I last saw h 18d alive on Oct 29 1946.

Immediate cause of death — Duration

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Grundmann M. D.
Address Johns Hopkins Hospital Date signed 10-30-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45329

Hospital Disposal

CHE-105546

D Cde D 60129 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G45329

Type or write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Fisk Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ricks, (Mamie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25-1946

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Lesaale Ricks
13. Birthplace Virginia

MOTHER
14. Maiden Name Mamie Ward
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 11-1-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

NOV 7 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946 to Oct. 28 1946 and that I last saw him alive on Oct. 28 1946.

Immediate cause of death: Massive pulmonary atelectasis — Duration 30 min.

Due to: Aspiration of milk

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: 11-1-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10-28-46 at 6:40 P.M.
(c) Where did injury occur? 2 Ward - B.C.H.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)
(e) Means of injury: Aspiration of milk

23. Signature Edward J. Mazanec M. D.
M. D.

Address Date signed

VS 180

5330 B.C.-J.-61792

Hospital Disposal

HB # 105450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G45330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 Etting St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Boy- Smith(Gloria)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	New Born

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1946

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name (Physician) Curry
13. Birthplace Pa.

MOTHER
14. Maiden Name Gloria Summers Smith
15. Birthplace Balto. Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11/1/1946 (month) (day) (year)
(c) crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 NOV 7 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1946 at 4:45A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1946 to Oct. 22 1946 and that I last saw him alive on Oct. 22 1946.

Immediate cause of death: Prematurity — Duration 4D

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William E. Hughes M. D.
Address Balto City Hosp Date signed Oct 22 46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G45331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS CAPIARELLO Also known as Luis Caballero

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. UNKOWN

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state) UNKOWN

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/8/46 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Elkridge City

18 (a) Funeral director Lilly & Zeller
(b) Address 403 E. Preston St

19 (a) NOV 7 1946 (Date rec'd by registrar) **(b)** Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1946, at 9.05 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Intracranial hemorrhage
Due to Fracture of right ribs (a 5 9)

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 5, 1946 - apprx. 8.30 p.m.
(b) Where did injury occur? 622 S. Bond St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from roof.

23. Signature Isaac A. Merrill M.D.
Medical Examiner.
Date signed 11-6-46

GG43382

BALTIMORE CITY HEALTH DEPARTMENT 168 GG43832

CERTIFICATE OF DEATH Registered No. Boarded: 1700 Thames St.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 2-3 Public
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME ANTONIO MEDINA) Mairano)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: UNKOWN

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1919

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace: C (Town, county, and state)

10. Usual Occupation: UNKOWN

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/46 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location Glen Dale Rd

18 (a) Funeral director Tilly & Zeh
(b) Address 2000 Eastern Ave

19 (a) NOV 7 1946 (Date rec'd by registrar) (b) Huntington Hilltop 4-3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1946 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Extensive second and third-degree burns
Bronchopneumonia
Myocardial degeneration
Pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-46 at 4.20 p. M.
(b) Where did injury occur? 1700 Thames St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Explosion and fire

23. Signature George G. Merrill M.D. Medical Examiner
Date signed 11/4/46

VS 181

G45333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G45333

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Caird St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linnie Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	Widowed

6 (b) Name of husband or wife Paul Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1897

8. AGE: Years	Months	Days	If less than one day
49	9	21	hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Brodie
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Chelsea Edwards
(b) Address 1628 W. Mulberry St.

17 (a) Burial (b) Date thereof Nov. 7, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mitchell & Williams
(b) Address 3229 W. Schroeder St.

19 (a) NOV 7 1946 Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1946 at 5:25 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10/30 1946 to 11/3 1946 and that I last saw h[illegible] alive on 11/3 1946.

Immediate cause of death Subarachnoid Hemorrhage — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Provident Hosp. Date signed 11/5/46

G45334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G45334
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 W Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 J
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lallie Ruth [redacted] Weeks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1876

8. AGE: Years 70 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Weeks
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Emory
15. Birthplace Maryland

16 (a) Informant Jerome A. Weeks
(b) Address 1707 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Vincents
Location Baltimore Md Druid Ridge Lane

18 (a) Funeral director Harry N Withe
(b) Address 401 Edmondson Ave

19 (a) (Title and name of registrar) (b) Huntington Williams M.D.
NOV 7 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Nov 5 1946 and that I last saw h[redacted] alive on Nov 5 1946

Immediate cause of death: Dilatation of the heart

Due to Bronchia

Due to Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury W H Pearce

23. Signature W H Pearce M. D.
Address 2405 E. Chase Date signed Nov 7

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 180

X 46

G45335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G45335 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Rolling Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Ray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-9-1890

8. AGE: Years 56 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Taxi Driver

11. Industry or business

FATHER 12. Name Dec.

13. Birthplace

MOTHER 14. Maiden Name Dec.

15. Birthplace

16 (a) Informant Mrs Louise Sch

(b) Address 202 Rolling Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8 1946 (month) (day) (year)

(c) Cemetery or crematory Loraine
Location Woodlawn Md

18 (a) Funeral director Harry W Wilkes

(b) Address 4101 Edmondson Ave

19 (a) (b)
(Date rec'd by local reg.) (Registrar)
NOV 7 1946 Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946 to 11-5 1946, and that I last saw him alive on 11-5 1946.

Immediate cause of death: Massive
Pulmonary embolus
Due to Phlebothrombosis of iliac veins
Due to
Other Condition Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary embolism

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollyes M. D.
Address St. Agnes Date signed 11-5-46

100 4

correct age is especially important. Physicians: please write the

G45336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G45336

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3126 Fait Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Fait Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH GRAULING

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William J. Grauling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1877

8. AGE: Years 68 | Months 10 | Days 17 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Miller
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Carrie L. Paff
15. Birthplace: Baltimore, Maryland

16 (a) Informant: William J. Grauling, Jr.
(b) Address: 3126 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11- 8-46 (month) (day) (year)
(c) Cemetery or crematory: First Evangelical Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) NOV 7 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1946 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1945 to 11-6 1946. and that I last saw h[illegible] alive on 11-5-1946.

Immediate cause of death: Carcinoma Pancreas — Duration 2 yrs
Due to: Metastasis to liver & stomach — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: H. J. Sander M. D.
Address 3218 Eastern Ave Date signed 11-6 46

VS 150

G45337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

877

Registered No. G45337

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 E. 30th. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 E. 30th. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA ROSE SEIPPEL

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frederick O. Seippel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1866

8. AGE: Years 80 | Months 1 | Days 23 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: August Sammall
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Hemple
15. Birthplace: Germany

16 (a) Informant: William A. Smith
(b) Address: 1611 E. 30th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11- 8-46 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) NOV 7 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH: Nov. 5 1946 at 8.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946 to Nov. 1946 and that I last saw h[illegible] alive on 3 Nov. 1946

Immediate cause of death: Myocardial Insufficiency — Duration: 3 wks
Due to: Arteriosclerosis — 10 years
Due to:
Other Conditions: Cerebral Sclerosis — 5 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Ley M. Zimmerman M. D.
Address 2858 Hayford Rd Date signed 5 Nov. 46

VS 150

G45338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Reg. No. G45338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 552 Orchard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 552 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE FISHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1869

8. AGE: Years	Months	Days	If less than one day
77	1	3	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah Burton
15. Birthplace Md.

16 (a) Informant George Fisher
(b) Address 552 Orchard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 7 1946 Edgar Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 5, 1946, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Nov 5 1946. and that I last saw him alive on Nov. 4 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 day.
Due to Arteriosclerosis	Typ. t
Due to	
Other Conditions Angina Pectoris + Hypertension.	Typ. t

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. S. Juliano Jr. M. D.
Address 511 N. Eutaw St. Date signed 11/6/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

5339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G45339 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Harwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin Abbott Greene

3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Daisy
6 (c) If married, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 19 1884
8. AGE: Y. 61 Months 10 Days 18 If less than one day hr. min.
9. Birthplace England. (Town, county, and state)
10. Usual Occupation
11. Industry or business
12. Name of FATHER Edwin F. Greene
13. Birthplace England.
14. Maiden Name of MOTHER Edna E. Woolford.
15. Birthplace Md.
16 (a) Informant Franklin A. Greene Jr.
(b) Address 607 Harwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8 46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem. Location Gorsuch Ave. & Loch Raven
18 (a) Funeral director John A. Hogan
(b) Address 3010 E. Baltimore St.
(c) NOV 7 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/ 1946, at 7:20 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1946 to 11/6 1946, and that I last saw h alive on 11/6/ 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to H. C. D. disease	
Coronary thrombosis	13 days
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C. C. Fauzalez M. D.
Address Maryland G. Hospital Date signed 11/6/46

VS 150

937

G45340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1258

Registration No. G45340

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address AMBASSADOR APTS. 703
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - F
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. AMBASSADOR APTS. 703 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. SAMUEL Packwood MORTON JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870 Sep 23

8. AGE: Years	Months	Days	If less than one day
76	1	13	hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)

10. Usual Occupation COFFEE MERCHANT

11. Industry or business

FATHER
12. Name SAMUEL Packwood MORTON
13. Birthplace BALTIMORE, Md.

MOTHER
14. Maiden Name CATHERINE MARGARET WIEGEL
15. Birthplace BALTIMORE

16 (a) Informant LEILA L. ROGERS
(b) Address ELLICOTT CITY, Md.

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 11 8 1946 (month) (day) (year)
(c) Cemetery or crematory GREENMONT
Location BALTIMORE, Md.

18 (a) Funeral director Henry W. JENKINS & Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) NOV 8 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1946, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to Nov 5 1946, and that I last saw h wife alive on Nov 5 1946.

Immediate cause of death Hepatitis — Duration 1 month

Due to Unknown

Due to

Other Conditions Chronic rheumatoid arthritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter B. Beck M. D.
Address 18 E. Eager St Date signed Nov 7

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G45341

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH: 24-4
(a) Baltimore City, Maryland
(b) Street address 1480 N. Carolina St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 WEBSTER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTOPHER V. MADDOX

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-1893

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lula E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1885

8. AGE: Years 61 Months 9 Days 24 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business B. & O R.R.

FATHER 12. Name Nicholas Maddox

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary A. Foy

15. Birthplace England

16 (a) Informant Lula E. Maddox

(b) Address 1627 Webster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) 8 1946 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1946 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/46 19 to 11-7 1946.
and that I last saw h alive on 11/7 1946.

Immediate cause of death Cardiorespiratory failure

Duration

Due to Acute Fibrillation

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Leonard

Address St Jos Hosp Date signed 11/12/46

VS 150

G45342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G45342 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., 1812-1
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 N. Charles St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country —

3 (a) FULL NAME Mrs. [redacted]. Onnen (Elma)
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dietrich F. Onnen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/68

8. AGE: Years 77 | Months 10 | Days 5721 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Thomas Whittington
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Cowling
15. Birthplace Virginia

16 (a) Informant Ferdinand Onnen
(b) Address Towson Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn. Balto Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 1212 St Paul St

19 (a) NOV 8 1946 (Date rec'd by registrar) (b) Huntington Whittington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1946, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1946 to Nov 7 1946, and that I last saw h.. alive on Nov. 7 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Carcinoma of Rectum	
Post operative	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin A. Hendrickson, 3rd M. D.
Address Union Memorial Hosp. Date signed 11-7-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G45343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G45343
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-9
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Renner

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ada E
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 14 1878

8. AGE: Years: 68 | Months: 8 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore MD (Town, county, and state)

10. Usual Occupation: Farm foreman Retired

11. Industry or business

FATHER
12. Name: Joshua Renner
13. Birthplace: Baltimore MD

MOTHER
14. Maiden Name: Mary Kuper
15. Birthplace: Baltimore MD

16 (a) Informant: Mollie E Cooke
(b) Address: 1808 Eutaw St

17 (a) Sinai (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)

(c) Cemetery or crematory: Baltimore
Location: Baltimore MD

18 (a) Funeral director: Hillyer Cook Dye
(b) Address: 1219 Eutaw St

19 (a) NOV 8 1946 (Date rec'd by registrar) (b) Interring or Removal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7th 1946 at 3 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1946 to Nov. 7th 1946 and that I last saw h in alive on Nov 7th 1946

	Duration
Immediate cause of death: Bronchopneumonia	
Due to: Neoplasm of Lung (type undetermined)	
Due to:	
Other Conditions: Arteriosclerotic Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: [redacted]
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Bessinger M.D.
Address Sinai Hospital Date signed 11/9/46

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

G45344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G45344 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-4
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 S. Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Parks (CHARLES G. PARKS)

3 (b) If veteran, name war: W.W. #1

3 (c) Social Security Account No. 212-16-3677

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Helen Parks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-4-97

8. AGE: Years	Months	Days	If less than one day
49	7	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Felting Factory

FATHER
12. Name Charles D. Parks
13. Birthplace Maryland

MOTHER
14. Maiden Name Addia [illegible]
15. Birthplace Maryland

16 (a) Informant: Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11-1946 (month) (day) (year)
(c) Cemetery (or crematory) Maisel's Church Home
Location Pikesville Ridge Rd

18 (a) Funeral director Roll & B. M. Walker
(b) Address Pratt & Stricker Sts

19 (a) (Date received by registrar) (b) Huntingtown, Williamsport, Md. Registrar

NOV 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1946, at 7 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1946, to 11-7 1946, and that I last saw h alive on 11-7, 1946.

Immediate cause of death	Duration
Carcinomatosis, primary site undetermined involving principally right lung and left kidney	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert C. Chesterman
Address Johns Hopkins Hosp Date signed Nov 6

X

G45345
397631

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 30D

Registered No. G45345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital pr inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 J. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Faidley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Rosie Faidley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-85

8. AGE: Years	Months	Days	If less than one day
61	7	10	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation steelworker

11. Industry or business

FATHER: 12. Name George Faidley; 13. Birthplace Va.

MOTHER: 14. Maiden Name Virginia Williams; 15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne A. County Md

18 (a) Funeral director Mrs. Britt. J. Lloyd + Dgt
(b) Address 1129 N. Caroline St.

19 (a) Nov 9 1946 (Date received by registrar) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946 at 11 57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1946 to 11-6- 1946 and that I last saw him alive on 11-6- 1946

Immediate cause of death UREMIA — Duration 1 month

Due to POLYCYSTIC KIDNEYS — LIFE

OTHER CONDITIONS: SYPHILITIC ANEURYSM OF AORTA WITH COMPRESSION OF BRONCHUS TO LEFT LOWER LOBE, ATELECTASIS

Other Conditions of LEFT LOWER LOBE; GENERALIZED CONGESTION OF VISCERA, ARTERIOSCLEROTIC

(Include pregnancy within 3 months of death)

Date of operation ARTERIOSCLEROTIC HEART DIS

Major findings of operation

of autopsy: ABOVE

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore L Stephens, M.D.
Address Johns Hopkins Hospital Date signed 11/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G45346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√ 117a

G45346 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 E. 25th St.
(c) Hospital or institution:
none 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Edgerton Riely

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Mary Patterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1884

8. AGE: Years	Months	Days	If less than one day
62	3	28	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation engineer
11. Industry or business

FATHER
12. Name Col. John J. Riely
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy R. Taylor
15. Birthplace Clark Co., Va.

16 (a) Informant Dr. Compton Reiley
(b) Address 2207 St. Paul St.

17 (a) Burial (b) Date thereof 11/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North Greenmount Aves.

18 (a) Funeral director John M. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov. 6 1946 and that I last saw him alive on Nov. 6 1946.

Immediate cause of death	Duration
Gastric hemorrhage	1 day
Due to Stomach ulcer	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty, M.D.
Address 37 W. Preston St. Date signed 11/7/46

VS 150 NOV 8 1946 Huntington Williams, M.D.

G45347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G45347 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Somerset Road
(c) Hospital or institution: None 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Somerset Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife E. Asbury Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1870

8. AGE: Years	Months	Days	If less than one day
76	8		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alex Conradt
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Poulson
15. Birthplace Md.

16 (a) Informant Francis A. Davis
(b) Address 304 Somerset Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) Date Rec'd by Registrar NOV 8 1946 (b) Registrar Huntington Whittington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1946, at 7:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1946 to Nov. 7 1946, and that I last saw h.. alive on Nov. 7 1946.

Immediate cause of death: Acute pulmonary edema — Duration

Due to: Hypertension and cardio-vascular disease. — 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Mungavin Jr. M.D.
Address 3301 N. Charles St. Date signed 11/8/46

8

X

G45348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G45348

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-7 Calvert & Saratoga St.
(c) Hospital or Institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Front St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME James Brady

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1865

8. AGE: Years	Months	Days	If less than one day
81	4	3	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name John Brady
13. Birthplace Ireland
MOTHER 14. Maiden Name Sarah
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date filed by registrar) NOV 8 1946 (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1946, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1946 to Nov. 7 1946, and that I last saw him alive on Nov. 7 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Cardiac decompensation — senile	2 mos.
Due to Arteriosclerotic Cardio-Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Connor M.D.
Address Mercy Hospital Date signed 11-8-46

VS 150

please write the causes of death clearly and legibly. Physicians: please

G45349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St
(c) Hospital or institution: Union Memorial Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hopkins Pl 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIAN GRACE PRICE

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry Allen Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 1, 1868

8. AGE: Years 78 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Frederick, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George W. Bantz
13. Birthplace Maryland (Frederick)

MOTHER
14. Maiden Name Sophia E Ortwein
15. Birthplace Maryland

16 (a) Informant Charles A Bantz
(b) Address 2900 Ulman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/46 19 — at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1946 to 11/7 1946 and that I last saw h[illegible] alive on 11/7 1946

Immediate cause of death: Cardiac failure — Duration 6 days
Due to Intermuscular tissue heart disease — Duration ?
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
— of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature [signature] M. D.
Address [illegible] Date signed 11/7/46

Hap X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G45350 **CERTIFICATE OF DEATH** 937 G45350 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Ferndale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Ferndale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN J. BARTHOLOMEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie Bartholomee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1867

8. AGE: Years	Months	Days	If less than one day
79	5	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John J. Bartholomee
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Md.

16 (a) Informant Mr. Wm. I. Bartholomee
(b) Address 3818 Ferndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS Balto., Md.
(b) Address

19 (a) NOV 8 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1946 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to Nov. 6 1946 and that I last saw him alive on Nov. 5 1946.

Immediate cause of death	Duration
Cardio Vascular Hyperten	8 yrs
Due to Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas A. Todd M.D.
Address 2108 St Paul St Date signed 11/7/46

VS 190

G45351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 G45351

Correct age is especially important. Physicians please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1733 Ashburton St.
(c) Hospital or institution: 15-L
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE V. SPONSLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles O. Sponsler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1857

8. AGE: Years	Months	Days	If less than one day
89	7	24	hr. min.

9. Birthplace York Co., Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Hunter
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Raymond
15. Birthplace York, Pa.

16 (a) Informant Mr. Charles E. Sponsler, Sr.
(b) Address 3030 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 8 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1946, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1946 to Nov. 7 1946 and that I last saw h er alive on Nov. 5 1946.

Immediate cause of death	Duration
Myocarditis Chronic	3 years
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Eugene L. Levering M. D.
Address 514 Druid Lane Date signed 11/7/46

VS 150

Huntington Williams, M.D.

X

G45352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G45352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Dillon St.
(c) Hospital or institution: Home 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Dillon St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mildred Selin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Charles Selin
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Sept 1911

8. AGE: Years	Months	Days	If less than one day
35	2		hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Ham Dresser
11. Industry or business

FATHER
12. Name Thomas Jenkins
13. Birthplace New Jersey

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Charles Selin
(b) Address 3116 Dillon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cemetery
Location Pulaski Highway

18 (a) Funeral director John J. Dudal
(b) Address 2029 Hudson St.

19 (a) NOV 8 1946 (b) Registrar
(Date rec'd by reg.)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946, at 9 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Octob. 1 1946 to Nov. 6 1946, and that I last saw h er alive on Nov. 6 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Rosenblatt M. D.
Address 3018 O'Donnell Date signed 11-7-46
Baltimore, 24, Md. X

G45353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G45353 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 Fait Ave
(c) Hospital or institution: Home 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Fait Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Majchrzak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Catherine Majchrzak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66 yrs			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Cecelia Zeller
(b) Address 2700 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 E. Eaton St.

19 (a) NOV 8 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1944 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1944 to Nov. 6 1944. and that I last saw h[illegible] alive on Nov. 6 1944

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Slawinski M. D.
Address 2589 Fenton Ave. Date signed

VS 3

G45354

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

Reg. G45354

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Calloway Ave
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Calloway Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME M. Lee Cohen
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Mrs. Sadie Cohen
(b) Address 3401 Calloway Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-46 (month) (day) (year)
(c) Cemetery or crematory B'NAI ISRAEL
Location SOUTHERN AVE

18 (a) Funeral director Jack Nevins Inc
(b) Address 1339 E. Balto St

19 (a) NOV 8 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1946 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18-1946 to 11-7-1946 and that I last saw h alive on 11-7-1946.

Immediate cause of death: Coronary Thrombosis — Duration 3 mo
Due to
Due to
Other Conditions Cerebral Embolism — 10 min
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Swooman
Address 1109 N. Eden St Date signed 11/9/46

VS 150

X

G45355 BC# G 58336 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 157E G45355 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution Balto. Md. 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6416 Brook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Joel Lynn
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29 1946

8. AGE: Years	Months	Days	If less than one day
0	1	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas J. Lynn
13. Birthplace La.

MOTHER
14. Maiden Name Marthilde Higgabotham
15. Birthplace La.

16 (a) Informant Marthilde Lynn
(b) Address 6416 Brook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/46 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Balto. Co. Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Rd.

19 (a) [illegible] (b) Huntington Williams, M.D.

NOV 8 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1946 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1946 to Nov. 7 1946, and that I last saw him alive on Nov. 7, 1946

Immediate cause of death Cardiac failure — Duration

Due to Congenital malformation of heart

Due to

Other Conditions Prematurity Bronchopneumonia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 11/9/46

G45356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G45356 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts 26-10
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 341 E. East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr Thomas Godwin

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-8666

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Frances Godwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Big Mill hand
11. Industry or business Rustless Steel

FATHER
12. Name Bruce M. Godwin
13. Birthplace Va

MOTHER
14. Maiden Name Lillian Herman
15. Birthplace Va

16 (a) Informant Frances Godwin
(b) Address 341 E. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Fred W. Ogorzenski
(b) Address 1980 Eastern Ave.

19 NOV 8 1946 Clinton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1946 to Nov 6 1946 and that I last saw h.LIVE alive on Nov 6 1946

Immediate cause of death — Duration

Cardiac Failure
Due to Arterial Fibrillation
Due to Mesenteric Embolism
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11-4-46
Major findings of operation: Mesenteric embolism
of autopsy (if performed) part of small intestine

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Wells M.D.
Address St Jos Hosp Date signed 11-6-46

VS 150

G45357

BALTIMORE CITY HEALTH DEPARTMENT X 94a ✓ Registered No. G45357

CERTIFICATE OF DEATH

S.S. Ward Hunt, A.H.Bull Co.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Aboard ship- S.S. Ward
(c) Hospital or institution: Hunt- A.H.Bull & Co.

(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days.

2. USUAL RESIDENCE OF DECEASED: Pier #5
(a) State Maine (b) County
(c) City or town Parker's Head.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Mank

3 (b) If veteran, name war ?

3 (c) Social Security Account No. 004-42-1373

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret Mank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-01

8. AGE: Years 45 | Months 9 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Parker's Head Maine
(Town, county, and state)

10. Usual Occupation Marine Engineer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Bull Steamship Line Records
(b) Address Pier 5 Pratt St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/8/46 (month) (day) (year)

(c) Cemetery or crematory
Location Bath Maine

18 (a) Funeral director Geo E Bayer Jr
(b) Address 512 Hollins St

19 (a) NOV 8 1946 Registrar

(b) Registered by Huntington Wilson Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1946, at 12.30 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haussman M.D.
Medical Examiner.
Date signed 11-7-46

G45358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G45358 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 661 Vine St.
(c) Hospital or institution: 4-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 661 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Harrison Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife Moses Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23 1878

8. AGE: Years	Months	Days	If less than one day
67	-	11	hr. min.

9. Birthplace Kent Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Owen Robinson
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Agnes Lee
15. Birthplace Kent Co. Md.

16 (a) Informant Carolyn Blunt
(b) Address 677 E. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Filed [illegible] by registrar NOV 8 1946 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1946 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1946 to 11/4 1946 and that I last saw h alive on 11/4 1946.

Immediate cause of death Pneumonia
Myocarditis
Due to Influenza
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 11/7/46 M. D.

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G45359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G45359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-10
(b) Street address
(c) Hospital or institution:
Union Memorial Hospital. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Old York Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Schroeder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5-1892

8. AGE: Years	Months	Days	If less than one day
54	10	2	hr. min.

9. Birthplace Chicago Ill
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Schroeder
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Rosalie Schroeder
(b) Address 4406 Old York Road
17 (a) Shipping (Burial, cremation, or removal) (b) Date thereof Nov 8 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago Ill
18 (a) Funeral director John G. McCann
(b) Address 3006 E. Baltimore St.
19 (a) Nov 8 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1946, at 1.05 P.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 11-7-46

VS 191

G45360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G45360 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-2
(c) Hospital or institution:
Provident Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT SAMUEL MOSES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1913

8. AGE: Years	Months	Days	If less than one day
33 32	S M.T.2	7	hr. min.

9. Birthplace Birdnest Va
(Town, county, and state)

10. Usual Occupation Empire Laundry Co

11. Industry or business

FATHER 12. Name William Moses

13. Birthplace Birdnest Va

MOTHER 14. Maiden Name Maria Stevenson

15. Birthplace Birdnest Va

16 (a) Informant Effie Taylor

(b) Address 1025 N Gilmor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 10 1946 (month) (day) (year)

(c) Cemetery or crematory Western Star

Location Baltimore County

18 (a) Funeral director Joseph A Sisly

(b) Address 661 West Baltimore Street

19 (a) NOV 8 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1946, at 10.50M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of Aorta, pericardial cavity, with tamponade.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-6-46 at 10.15 p. M.

(b) Where did injury occur? Gilmor & Laurens St.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Firearm Shot during altercation

23. Signature Howard J. Wallace M.D.
Medical Examiner.

Date signed 11-7-46

X

45361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A-37286 302 153

G45361 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [redacted] HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town PASADENA. (If outside city or town limits, write RURAL and give town)
(d) Street No. Box-28 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Phillip Sylvester Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-44

8. AGE: Years	Months	Days	If less than one day
2	9	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Md

MOTHER
14. Maiden Name Grace Johnson
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-46 (month) (day) (year)
(c) Cemetery or crematory Mayo the Cem. Location A. A. County Md
18 (a) Funeral director William Jackson
(b) Address 916 Fenton Ave
19 (a) NOV 8 1946 (Date rec'd by registrar) [signature] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946 at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4- 1946 to 11-6- 1946, and that I last saw h[illegible] alive on 11-6- 1946.

Immediate cause of death: Pneumonia Staphylococcus
Due to: Acute Chronic Cyanosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Johns Hopkins Hosp. Date signed 11-6-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45362

BALTIMORE CITY HEALTH DEPARTMENT ✓ G45362
CERTIFICATE OF DEATH 170c
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 24-1
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Charles Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Mary C. Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21-1892

8. AGE: Years: 54 | Months: 6 | Days: 16 | If less than one day: hr. min.

9. Birthplace Atlanta Ga. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Taylor
13. Birthplace England

MOTHER 14. Maiden Name Rose Forsythe
15. Birthplace Ireland

16 (a) Informant Mrs. Mary C. Taylor
(b) Address 1518 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) NOV 8 1946 (Date received by Registrar) (b) Huntington Williamsport Md. Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH November 7th 1946, at 12 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Multiple fractures, lacerations, burns, hemorrhage,

Other Conditions avulsion of tissues

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/1
(a) Date of injury 11/6/46 at 10:15 P M.
(b) Where did injury occur? 400 blk Hanover St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by truck

23. Signature Howard J. Weaver M.D. Medical Examiner.
Date signed 11-7-46

VS 151

G45363
CWK-106400

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45363 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1m 28d
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Barnes Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alton Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29-1924

8. AGE: Years	Months	Days	If less than one day
21	11	8	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward
13. Birthplace North Carolina

MOTHER
14. Maiden Name Roney ?
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Shipped (b) Date thereof 11 8 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Raleigh
Location North Carolina

18 (a) Funeral director Rayney Sanders
(b) Address 1413 E. Preston St

19 (a) Filed (b) Registrar
(Date received by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1946 to Nov. 7 1946, and that I last saw h. im alive on Nov. 7 1946.

Immediate cause of death	Duration
Cerebral Embolism	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions Patent Duct Endocarditis, Arteriosclerosis	Years
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Found as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. R. Hertzbrough M.D.
Address Balto City Hosp Date signed 11-9-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G45364
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-3
(b) Street address Caton & Wilkinson
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph ~~Cass~~ Kimball (Joseph M. KIMBALL)

3 (b) If [illegible], name of war: None

3 (c) Social Security Account No. 219-03-0723

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian E. Kimball

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov 12 1887

8. AGE: Years 58 | Months 11 | Days 27/36 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Boat watchman

11. Industry or business

FATHER
12. Name deceased-James C. Kimball
13. Birthplace Md

MOTHER
14. Maiden Name deceased-Sarah M. Giles
15. Birthplace Md

16 (a) Informant Lillian E. Kimball
(b) Address 367 Maydell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11-1946 (month) (day) (year)

(c) Cemetery or crematory Baltimore City
Location Loft Q. B.M. Walters

18 (a) Funeral director Pratt Stacker & S
(b) Address

19 (a) (b) Huntington Williams

NOV 8 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8 1946 at 12 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on 11-8 1946.

Immediate cause of death: acute uremia
poisoning

Due to: Urinary retention,
chronic

Due to: Benign prostatic hypertrophy

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Sampley M. D.
Address Saint Agnes Hosp. Date signed 11-8-46

X

158 G45365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G45365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 264
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (If outside city or town limits, write RURAL and give town)
(d) Street No. 5023 E. Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Jean Long
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-15-37

8. AGE: Years	Months	Days	If less than one day
8	10	22	hr. min.

9. Birthplace W. Va. - (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hollis Long -
13. Birthplace W. Va. -

MOTHER
14. Maiden Name Wanda Jeffries
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-46 (month) (day) (year)
(c) Cemetery or crematory Mountain
Location South Philippi, West Virginia

18 (a) Funeral director Frederick D. Mellon Jr.
(b) Address 3019 E. Monument St.

19 (a) (b) Registrar
Date rec'd by registrar NOV 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1946, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1946 to Nov 7 1946 and that I last saw her alive on Nov 7 1946

Immediate cause of death	Duration
Cerebral Edema	24 hrs.
Due to Brain Stem Tumor	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nov 6, 1946
Major findings of operation: Recurrent astrocytoma of brain stem
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur B. Shipley
Address Johns Hopkins Hosp. Date signed 11/9/46

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G45366 BC# b77350 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G45366

1045 S. Dallas St 161a

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1045 Dallas St
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1045 Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Junior

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex M | **5. Color or race** C | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace ? Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Anthony Thomas Queen
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Bernice Elizabeth Junior
15. Birthplace South Carolina

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 8 1946 (Date rec'd by registrar) Thos. J. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Oct 1946 at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Atelectasis Neonatorum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at P.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Kelbach M.D.
Medical Examiner.
Date signed 20 Oct 46

VS 191

Over

X

Hospital Disposition

CWK-105244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 59605 — 119a — Registered No. G45367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 537 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby James Treves, (Traves)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13/46

8. AGE: Years	Months	Days	If less than one day
0	0	16	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Unknown

13. Birthplace

MOTHER — 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11-1-46 (month) (day) (year)
(c) [redacted] crematory Baltimore City Health
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

NOV 8 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946, at 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1946, to Oct. 29 1946, and that I last saw him alive on Oct. 29 1946.

Immediate cause of death Malnutrition, dehydration, sepsis and atelectasis — Duration 15 d

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp Date signed Oct 31 46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G45368 Registered No.

1. PLACE OF DEATH: 10-2
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith St.
(c) Hospital or institution: Notre Dame Convent
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Sister Mary Judith Brandenburger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed,~~ or ~~divorced~~
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1877

8. AGE: Years	Months	Days	If less than one day
69	6	25	hr. min.

9. Birthplace Rochester N.Y. (Town, county and state)
10. Usual Occupation Religious.
11. Industry or business

FATHER — 12. Name	Frederick Brandenburger
FATHER — 13. Birthplace	Rochester N.Y.
MOTHER — 14. Maiden Name	Margaret Guthsberger
MOTHER — 15. Birthplace	Rochester N.Y.

16 (a) Informant Sr. Mary Hosp
(b) Address 901 Aisquint St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Glen Arm
18 (a) Funeral director Geo. M. Smith Son
(b) Address 811 N. Wolfe St
19 (a) Filed by registrar NOV 8 1946 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1946 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Nov 6 1946 and that I last saw h[illegible] alive on Nov 6 1946

Immediate cause of death — Duration

Bronchopneumonia

Due to Left Metastatic carcinoma

Due to L. lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8 years ago

Major findings of operation: Ca carcinoma L. lung

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. J. Kirby M. D.
Address 4000 North Ave Date signed 11/8/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45369 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G45369

CERTIFICATE OF DEATH

138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-12
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ months
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 341 Tunbridge Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald J. Giblin (Donald J. Giblin,)

3 (b) If veteran, name war --

3 (c) Social Security Account No. 216-18-0923

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1924

8. AGE: Years 22 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)

10. Usual Occupation Clerk,

11. Industry or business Western Electric Co.

FATHER
12. Name Robert E. Giblin,
13. Birthplace Delaware, Ohio,

MOTHER
14. Maiden Name Margaret A. Rabb,
15. Birthplace Morton Park, Ill.

16 (a) Informant Mr. Robert E. Giblin,
(b) Address 341 Tunbridge Road,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore City,

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 8 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1946, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1946 to 11-7 1946, and that I last saw him alive on 11-7 1946.

Immediate cause of death	Duration
Ventricular fibrillation	
Due to Tuberculous meningitis	
Due to	
Other Conditions Diabetes mellitus, Pulmonary tuberculosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
Date of autopsy: Tb. meningitis & pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Harley, M. D.
Address Univ. Hosp. Date signed 11-7-46

X

G45370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45370
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 St Paul St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) — ? —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll Co
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. Fairhaven Farms (If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Bennett Beasman

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Johnzie C. Beasman
6 (c) If given, give age — years
7. Birth date of deceased (mo., day, yr.): Sept 28 1856

8. AGE: Years 90 | Months 1 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore Co (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: Elisha H. Bennett
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Mary E. Bennett
15. Birthplace: Carroll Co.

16 (a) Informant: Mr F. B. Beasman (son)
(b) Address: 4301 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-46 (month) (day) (year)
(c) Cemetery or crematory: Springfield Cemetery
Location: Sykesville Md

18 (a) Funeral director: Stuart Mason Co.
(b) Address: 108 W Mt Ave.

19 (Date received by registrar) NOV 13 1946 Huntington, Williams, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946, at 9 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Nov 8 1946 and that I last saw deceased alive on Oct 31 1946

Immediate cause of death: Bronchial Pneumonia — Duration: 3 days
Due to: age
Due to: arthritis & senility
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible]
Address: [illegible] M. D.

VS 150

G45371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G45371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 Greenway Apts
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto city
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 E Chase St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bore Chamberlaine

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1855

8. AGE: Years 91 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Norfolk Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Richard Henry Chamberlaine
13. Birthplace Norfolk. Va.

MOTHER
14. Maiden Name Maria Toney.
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Robert L Chamberlaine
(b) Address Greenway apts

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov-9-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Burial
Location Baltimore Md

18 (a) Funeral director Stewart Monroe
(b) Address 108 W Monument

19 NOV 9 1946 Registrar

VS 180

Huntington Hillcrest, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1946, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946, to Nov. 7 1946, and that I last saw h[illegible] alive on Nov. 6 1946.

Immediate cause of death Cerebral Vascular Accident — **Duration** 2½ Mo.

Due to arteriosclerosis — many years

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W. Stuart M. D.
Address 715 Park Ave **Date signed** 11/7/46

X

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G45372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45372 178a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. Monastery Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Monastery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Mahlmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 Months Days If less than one day hr. min. D.M. X6

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation — None

11. Industry or business —

FATHER
12. Name Herman H. Mahlmann
13. Birthplace Germany

MOTHER
14. Maiden Name Dorette Allman
15. Birthplace Germany

16 (a) Informant Wm. F. Reitz, Sr.
(b) Address 225 S. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wright
(b) Address 4401 E. Monument Ave
(c) Huntington Williams Mgr. Richmond

NOV 9 1946 (Date rec'd by Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1946, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-7-46 at 9:30 A. M.
(b) Where did injury occur? 1125 S. Monastery Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas fumes from suicide

23. Signature [illegible] M.D. Medical Examiner.
Date signed 11-7-46

X

45373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G45373 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 S. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Kerr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	widowed

6 (b) Name of husband or wife Late Mary S. Linton 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1859

8. AGE: Years	Months	Days	If less than one day
87	-	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Kerr
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane
15. Birthplace Maryland

16 (a) Informant Miss Alice M. Kerr
(b) Address 1521 W Lombard St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-9-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md.

18 (a) Funeral director Harry H. Wittke
(b) Address 4101 Edmondson Ave

NOV 9 1946 (Date rec'd by local registrar) Huntington Williams M.D. (Signature)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1946 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Nov. 6 1946 and that I last saw him alive on Nov. 5 1946.

Immediate cause of death	Duration
Arteriosclerotic heart disease	?
Due to Generalized arteriosclerosis	?
Due to advanced age.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Schreiber M. D.
Address 57 S. Fulton Ave Date signed 11-8-46

G45374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G45374 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Dixon Road
(c) ~~Hospital or institution~~ Mt Washington
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1967

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Dixon Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH TACK GWINN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife RICHARD Gwinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Ap. 7 - 1872

8. AGE: Years	Months	Days	If less than one day hr.	min.
74	7	0		

9. Birthplace PITTSBURG PA (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name THEODORE TACK
13. Birthplace

MOTHER 14. Maiden Name MARY COSGRAVE
15. Birthplace

16 (a) Informant ELIZABETH GWINN
(b) Address 1809 DIXON RD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 9 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Henry McSherry Thompson
(b) Address McCulloh & Orchard Sts

NOV 9 1946 Dist. rec'd by Registrar Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1946 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1938 to Nov 7 1946 and that I last saw her alive on Nov 6 1946

Immediate cause of death
Pneumonia
Rx Breast.

Duration Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W P Healy M. D.
Address 140 S Paca St Date signed 11/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

VS 150

G45375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G45375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 S. Payson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Payson St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Georgie Medders Clark

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Sewell T. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1873
8. AGE: Years 73 | Months 4 | Days 3 | If less than one day: hr. min.
9. Birthplace Crumpton, Queen Anne County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Perry W. Ruth
13. Birthplace Maryland

MOTHER
14. Maiden Name Sally ?
15. Birthplace Maryland

16 (a) Informant Mary W. Clark
(b) Address 220 S. Payson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

19 NOV 9 1946 (Date rec'd by reg.) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 6 1946 and that I last saw h[illegible] alive on Nov 6 1946

Immediate cause of death	Duration
Myocardial degeneration	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. G. Jamison
Address 2818 A. Payson Date signed Nov 7 1946 M. D.

945376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G45376

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 W. Fayette St Balto
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Lutz, Florida
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 E. Powhatan
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK FRIMMER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/1880

8. AGE: Years	Months	Days	If less than one day
66	11	8	hr. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation Architect
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Mayd Rigby
(b) Address Annapolis Md

17 (a) Removal (b) Date thereof 11/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Annapolis Md

18 (a) Funeral director C. O. Hopkins
(b) Address Annapolis Md

19 (c) NOV 9 1946 Huntington Williams, M.D.
Registered by registrar 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1946, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5-1946, to 11-8-1946, and that I last saw him alive on 11-8-1946.

Immediate cause of death Congestive Heart Failure

Due to Hypertensive-Arterio-Sclerotic-cardio-vascular-dis.

Due to

Other Conditions Myocardial infarction. Diabetes mellitus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Mantley, M.D.
Address Bon Secours Hosp. Date signed 11-8-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45377

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45377 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs 30 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Carroll Co.
(a) State Md. (b) County Westminster
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 280 E. Green St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Orhum

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife John Wesley Orhum 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1871

8. AGE: Years	Months	Days	If less than one day
75	0	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Poole
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Murray
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)
(c) Cemetery or crematory Calvary Cem.
Location Damascus Carroll Co.

18 (a) Funeral director J. E. Myers Jr.
(b) Address Westminster, Md.

NOV 9 1946 Huntington Williams
(Date rec'd by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8 1946 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1946 to 11-8 1946 and that I last saw h alive on 11-8 1946

Immediate cause of death Cerebral Vascular Accident Collapse — Duration

Due to H.C.V.D., Sundle Branch Block, Diabetes Mellitus,

Due to Senile Psychosis,

Other Conditions Pneumonia, Gastroenteritis, Decubitus.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. A. Shallenberger M.D.
Address University Hospital Signed 11-8-46 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45378

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 135a

G45378 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 Harford Ave
(c) Hospital or institution ~~JOHNS HOPKINS HOSPITAL~~
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30d
(e) Length of stay in Baltimore (yrs., mos., or days) ~~30d~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Shadyside
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Groan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Benjamin Groan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/31/73

8. AGE: Years 73 | Months 7 | Days 9 | If less than one day: hr. min.

9. Birthplace Churchton Anne Arundel, Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lewis Sorrell
13. Birthplace Anne Arundel Co Maryland

MOTHER
14. Maiden Name Josephine Griffin
15. Birthplace Anne Arundel Co. Maryland

16 (a) Informant Mrs Beatrice Parrish
(b) Address ~~JOHNS HOPKINS HOSPITAL~~ 1223 Harford Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Churchton Md

18 (a) Funeral director J. B. Duncan
(b) Address Annapolis

19 (a) NOV 9 1946 (Date rec'd by registrar) Huntingtown Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1946, at 2:50 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1946, to 11/2 1946, and that I last saw h alive on 11/2 1946

Immediate cause of death Cardiac arrest — Duration

Due to Hypertensive cardiovascular renal disease — 2 months

Due to

Other Conditions Infected Hiatus Hernia Tract — 6 weeks
? Neoplasm Kidney
(Include pregnancy within 3 months of death)

Date of operation 10/31/46

Major findings of operation: Cystitis Cystectomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Newton Long, M. D.

Address 601 N. Broadway Date signed 11/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45379

CEK-102773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G45379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 26-
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Light Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sanford Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1881

8. AGE: Years ? 65 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace North Carolina

MOTHER
14. Maiden Name ?
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) NOV 9 1946 (Date received by registrar) (b) Registration No. 1

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1946, to Nov. 6 1946, and that I last saw h im alive on Nov. 6 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to: Bronchopneumonia + — yrs

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 11/7/46

correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS 150

G45380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G45380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1830 N. Collington
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 N. Collington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hicks Howard (HICKS FULTON HOWARD)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-12-3050

4. Sex: m

5. Color or race: w

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 13, 1880

8. AGE: Years 66 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace: Wicomico Co., Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Baltimore Police Dep't.

FATHER
12. Name: James Howard
13. Birthplace: Wicomico, Maryland

MOTHER
14. Maiden Name: Rachael Phillips
15. Birthplace: Wicomico, Maryland

16 (a) Informant: Mrs. Daisy Howard - widow
(b) Address: 1830 N. Collington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/11/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 9 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/46 19 , at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease
Due to

Other Conditions
Diabetes Mellitus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Weems, M.D.
Medical Examiner.
Date signed 11/8/46

VS 151

937

G45381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G45381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden and Madison Sts
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Rural - Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 268 East Green St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7/1880

8. AGE: Years	Months	Days	If less than one day
66	8	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Junk Dealer
11. Industry or business

FATHER
12. Name Isaac Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Walkowitz
15. Birthplace Russia

16 (a) Informant Ezra Cohen
(b) Address 5006 Chalgrove Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10/46 (month) (day) (year)
(c) Cemetery or crematory Mishkin Israel Cong Cemetery
Location Southern Ave.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1126-26 W. North Ave.

19 NOV 9 1946 Huntington Williams M.D. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7th 1946, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30/1946 to 11/7/1946, and that I last saw h alive on 11/7/1946.

Immediate cause of death	Duration
Cardiac failure	
Due to B. C. V. disease	
Due to	8 days.
Other Conditions Diabetes mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Gonzales
Address Maryland G. Hospital Date signed 11/13/46

VS 150

937

G45382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G45382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 Battery ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Battery ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin L. Raysinger
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Eliz W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1865

8. AGE: Years	Months	Days	If less than one day
81	10	3	hr. min.

9. Birthplace Baltimore md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Raysinger
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Desire
15. Birthplace Ireland

16 (a) Informant Mrs Wm Scheihing
(b) Address 1402 Battery ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location

18 (a) Funeral director Wm F. Porter
(b) Address 2836 W. North ave

NOV 9 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946, at 80 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1946 to Nov 8 1946 and that I last saw h alive on Nov 8 1946.

Immediate cause of death – Chronic Endocarditis — Duration 6 mos.
Due to Arterio Sclerosis — 1 yr.
Due to – Pulmonal Anasarca — 3 mos.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature C. B. Wheeler M. D.
Address 1279 Hillsdale Date signed 11/8/46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

C5383 Cates
517 Scott St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

Registered No. C5383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1244 Carroll Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 Carroll Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Mc Closkey

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife James E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1870

8. AGE: Years	Months	Days	If less than one day
76	1	14	hr. min.

9. Birthplace Havre De Grace, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Ed. Coffey
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Crowley
15. Birthplace Ireland

16 (a) Informant Mr. Gerald Mc Closkey
(b) Address 2708 Hemlock Avenue

17 (a) Burial (b) Date thereof 11/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

(Date received) 1946 (By) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nove. 7th, 1946, at 2:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1946 to Nov. 7 1946.
and that I last saw h 21 alive on Nov. 7th 1946

Immediate cause of death
(a) Carcinoma of bladder — Duration 8 months
Due to Nephritis — 4 months
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Kate
Address 517 Scott St Date signed Nov 8/46 M. D.

VS 150

X

G45384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G45384 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6010 Belona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6515 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Yockel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife: Marie R. Yockel
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) May 10th 1889

8. AGE: Years	Months	Days	If less than one day
57	5	28	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Own Business
11. Industry or business: Oil Burner

FATHER
12. Name: Frederick Yockel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Hoffmeister
15. Birthplace: Germany

16 (a) Informant: Marie R. Yockel
(b) Address: 6515 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 E. Read St.

19 (a) NOV 9 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8th 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946, to Nov 8 1946, and that I last saw him alive on Nov 8 1946.

Immediate cause of death: Paralysis — Duration 4 mos.
Due to:
Due to:
Other Conditions: Cerebral Hemorrhage — Duration unkn.
(Include pregnancy within 3 months of death.)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: A. A. Richardson
Address: 112 W. 25th Date signed: Nov. 9, 46

VS 150

G45385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G45385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 542 E. 22nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James W. Kelly

3 (b) If veteran, name war: Spanish-American

3 (c) Social Security Account No. 218-14-7811A

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) July 15th 1878

8. AGE: Years	Months	Days	If less than one day
68	3	23	hr. ——— min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Asst. Foreman

11. Industry or business Mt Vernon Laundry

FATHER
12. Name Charles Kelly
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Fisher
15. Birthplace Md.

16 (a) Informant Mrs. Amanda Nolan
(b) Address 542 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St

19 (Date received by registrar) NOV 9 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8th 1946, at 9:8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1946, to 11/9 1946, and that I last saw h. alive on 11/8 1946.

Immediate cause of death: Acute Coronary Occlusion — Duration 46 min

Due to: Coronary Arteriosclerosis — 8 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. White M. D.
Address 502 E 22nd St Date signed 11/9/46

VS 150

X

G45386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45386 Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 S. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** John C. Quinn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary J.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name John Quinn

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Unknown

15. Birthplace Md

16 (a) Informant William Quinn

(b) Address 3022 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Lebanon

Location Baltimore Md

18 (a) Funeral director John J. Cowan & Son

(b) Address 961 Hollins St.

19 (a) NOV 9 1946 rec'd (b) Registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 19 to Nov 7 1946 and that I last saw him alive on Nov 17 19 46.

Immediate cause of death: Cerebral Hemorrhage Rt — Duration 2 1/2 days

Due to Arteriosclerotic hypertension C V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Cashahan M.D.

Address 24 N. Fraction Ave Date signed 11/9/46

G45387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 91a

Registered No. G45387

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered before you write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE, 13.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 E. PRESTON St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA. M. DEVEAU

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1924.

8. AGE: Years 22 | Months - | Days 25 | If less than one day: hr. min.

9. Birthplace Brooklyn N.Y. (Town, county, and state)
10. Usual Occupation Spoolwinder.
11. Industry or business Waverly Mills.

FATHER: 12. Name Peter J. Deveau.
13. Birthplace Canada.

MOTHER: 14. Maiden Name Frances Jane Sanborn
15. Birthplace Mass.

16 (a) Informant Parents.
(b) Address 2705 E. Preston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 11 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles E. Schisler and
(b) Address 426 E. Madison Street.

19 (a) NOV 9 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8- 1946 at 450 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7-46 1946 to 11-8-46 1946, and that I last saw h alive on 11-8-46 1946.

Immediate cause of death: Cardio Respiratory failure
Due to: Cerebral Embolism
Due to: Subacute Bacterial Endocarditis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 14 [illegible] Date signed 11/8/46 (M. D.)

VS 150

G45388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G45388 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Sep

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Chaleston, S. C. (Town, county, and state)

10. Usual Occupation Handyman

11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace S. C.

MOTHER
14. Maiden Name Mattie Tebbens
15. Birthplace S. C.

16 (a) Informant Mattie Norris
(b) Address 713 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Chaloon
Location Columbia, S. C.

18 (a) Funeral director Elroy D Wilson
(b) Address 1000 Bonitly Ave

NOV 9 1946 Date rec'd by local registrar Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1946, at 3 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis
Tuberculous Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 11/7/46

VS 191

G45389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Tolson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-4821

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1889

8. AGE: Years 57 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Albany, Ga. (Town, county, and state)

10. Usual Occupation Cement Finisher

11. Industry or business

FATHER
12. Name Warner Tolson
13. Birthplace Albany, Ga.

MOTHER
14. Maiden Name Penny Howard
15. Birthplace Albany, Ga.

16 (a) Informant Alice Tolson (Wife)
(b) Address 531 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave

19 (a) Date rec'd by (Registrar) NOV 9 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1946 at 3:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Head & Chest
Due to Broken neck

Other Conditions Multiple fractures, brush burns.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-5-46 3 P. M. 27/15
(b) Where did injury occur? Nelson Ave. 100 ft. west of Belvedere Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell, struck by truck

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 11-6-46

VS 191

X

G45390 BC# F 29247 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH G45390 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Furley Ave
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore - 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4309 FURLEY AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances ADER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1941

8. AGE: Years	Months	Days	If less than one day
5	5	3 4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business

FATHER
12. Name FRANK ADER
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name Carmella Angelo
15. Birthplace Baltimore Md

16 (a) Informant Mr. Frank Ader
(b) Address 4309 Furley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-46 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Balto Md.

18 (a) Funeral director George A Weber
(b) Address 705 S Amity St

19 (a) NOV 9 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8 1946, at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute meningococcic meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 11/9/46

145391 G45391 BALTIMORE CITY HEALTH DEPARTMENT G45391
CERTIFICATE OF DEATH 46M Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Pernikoff
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-09-1977
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Freda
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1883
8. AGE: Years 63 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Tailor
FATHER 12. Name Abraham Pernikoff
13. Birthplace Russia
MOTHER 14. Maiden Name Etta ?
15. Birthplace Russia
16 (a) Informant Benjamin Pernikoff
(b) Address 1717 Gwyns Falls Parkway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
19 (a) (Date rec'd by registrar) (b) Registrar

NOV 10 1946
VS 150

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov 9 1946 at 5:45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1946 to Nov 9 1946 and that I last saw h[illegible] alive on Nov 9 1946.
Immediate cause of death Myocardial [illegible] Duration
Due to Arterio sclerotic Heart Disease
Due to
Other Conditions Bronchogenic cancer Carcinoma of Br. Trait.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herman Blisses MD
Address Sinai Hospital Date signed 11/9/46

Every item of information should be carefully supplied. Use black ink and write the causes of death clearly and legibly. Physicians: please write legibly. Correct age is especially important.

G45392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92P

G45392 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Walbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edith C. Crews.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife George W Crews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10. 1868

8. AGE: Years	Months	Days	If less than one day
78	7	24	hr. min.

9. Birthplace Beaver Road Va
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Lucy Reed
13. Birthplace

MOTHER
14. Maiden Name Claudia Devere
15. Birthplace unknown

16 (a) Informant Mrs. Henry R. Barnes
(b) Address 1804 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Gwynn Oak Ave.

18 (a) Funeral director G. Kenward Thomas
(b) Address 1541 E. Baltimore Ave.

19 (a) (Date rec'd by registrar) (b) Livingston Williams, Registrar

NOV 10 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1946, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov. 8. 1946 and that I last saw h alive on Nov. 8 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	11/1/46
Due to	
Due to Chr. Myocarditis	1943
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Brown
Address 1663 N. Smith Ave Date signed 11/8/46

X

G45393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G45393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ———
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 549 E. 38th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ———

3 (a) FULL NAME HOWARD A. WARREN

3 (b) If veteran, name war ———

3 (c) Social Security Account No. 213-07-2639

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wh	M

6 (b) Name of husband or wife Mrs. Howard A. Warren
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1911

8. AGE: Years	Months	Days	If less than one day
35	10	2	—hr. —min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Tobert C. Warren
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Hermie A. Warren
15. Birthplace Pennsylvania

16 (a) Informant Hospital record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-46 (month) (day) (year)
(c) Cemetery or crematory Mount Lodge.
Location Old. Frederick Rd.

18 (a) Funeral director John. A. Jordan
(b) Address 3600 E. Balto. St.

19 (a) Date received by registrar NOV 10 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1946, at 9:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 20 1946, to November 8 1946, and that I last saw him alive on November 8 1946.

Immediate cause of death	Duration
Carcinomatosis of lung.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ———
of autopsy: ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— (Specify type of place) While at work? ———
(e) Means of injury ———

23. Signature Crawford W. Fitzpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed Nov 6, 1946

VS 150

X

G45394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G45394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in typewriting or with pen and ink. Do not use pencil. Do not abbreviate or use ditto marks. If unknown or not applicable, write the word. Physicians: please write the causes of death clearly and legibly. Cause of death may be entered in either Part 1 or Part 2. Part 1 should be used for the principal cause of death, that is, the disease, injury, or complication which directly caused death. Part 2 should be used for other significant conditions contributing to death but not related to the principal cause given in Part 1. Certifier is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights
(c) Hospital or institution: Mt. Sinai Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isidore Katzen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Leng

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 55 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoe maker

11. Industry or business

FATHER 12. Name Lazb Katzen

13. Birthplace Russia

MOTHER 14. Maiden Name Lena

15. Birthplace Russia

16 (a) Informant Israel Lewis

(b) Address 3001 Wylie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phil Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

(c) Huntington Williams, M.D. Registrar

NOV 10 1946 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-46 19 at 6.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 19 to 11/7 19 46 and that I last saw h alive on 11/7 19 46

Immediate cause of death Peritonitis obstruction due to carcinoma.

Due to Gen'l Adominal carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9.14.46.

Major findings of operation: Carcinoma of sigmoid

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.

Address 733 Argyle St Date signed 11/8/46

VS 150

G45395 BALTIMORE CITY HEALTH DEPARTMENT G45395

CERTIFICATE OF DEATH 1927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ISRAEL KRAVETZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rebecca Ruth a Kravetz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) —— 1866

8. AGE: Years 60 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor + Furrier

11. Industry or business

FATHER 12. Name Elijah Darvon —

13. Birthplace Russia

MOTHER 14. Maiden Name Leah —

15. Birthplace Russia

16 (a) Informant Rebecca L. Kravetz

(b) Address 1537 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location

18 (a) Funeral director Jos. Levin Inc

(b) Address 1739 E. Balto. St

19 (a) (Date received by Local Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8/46 19 , at 12.45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner

Date signed 11/8/46

X

Write age if expressly unknown. Physician's plain writing.

G4539 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G4539 5

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4017 Springdale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY B. HAMBURGER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Amelie E. Hamburger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1858.

8. AGE: Years	Months	Days	If less than one day
88	2	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Salesman.
11. Industry or business

FATHER
12. Name Abraham Hamburger,
13. Birthplace Germany.

MOTHER
14. Maiden Name Eva ?
15. Birthplace Germany.

16 (a) Informant Mr. Stanley H. Hamburger,
(b) Address 4017 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/46. (month) (day) (year)
(c) Cemetery Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris & Levering & Son
(b) Address 1902 Eutaw Place.
(c) Date received by registrar NOV 10 1946 Filed for Williams Register

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th. 1946 at 4:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to Nov 9 1946, and that I last saw h/m alive on Nov 1 1946

Immediate cause of death: Heart block. — Duration: 1 day

Due to: arterio-sclerotic cardio-vascular disease — 3 years

Due to:

Other Conditions: Hemoglobin — 6 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Silver M. D.
Address Temple Garden Apts. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G45397 — BALTIMORE CITY HEALTH DEPARTMENT — G45397 Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Clifton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days).
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Clinton St
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Schlag

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Adolph H Schlag
6 (c) If alive, give age 80 yrs

7. Birth date of deceased (mo., day, yr.) Jan 10 1865

8. AGE: Years	Months	Days	If less than one day
81	9	22	hr. min.

9. Birthplace Germany (Town, county, state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Ruehl
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Woelbrack
15. Birthplace Germany

16 (a) Informant Mrs Helena Roth
(b) Address 1521 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11 (month) (day) (year)
(c) Cemetery or crematory Pastwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Aliceanna St Balto

19 (a) NOV 10 1946 (b) Huntington Williams, MD
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946, at 7 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/46 to 11/9/46, and that I last saw h alive on 11/8/46.

Immediate cause of death:
Hypostatic Pneumonia — Duration 1 wk
Due to Myocardial Degeneration — 1 mo
Due to Arteriosclerosis — 3 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H Heyman
Address 1710 E 33rd St Date signed 11/9/46

VS 150

G45398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164B

G45398 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Same Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 McKim St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William G. Kunkel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Kunkel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1912

8. AGE: Years	Months	Days	If less than one day
34	4	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Umbrella repairer
11. Industry or business

FATHER 12. Name John H. Kunkel Sr.
13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Emma L. Wallace
15. Birthplace Baltimore, Md.

16 (a) Informant Mary C. Kunkel
(b) Address 805 McKim St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Edgar H. Conkling & Son
(b) Address 924 E. Eager St.
(c) Huntington Williams, M.D.
NOV 10 1946 (Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7th 1946, at 4 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning.

Due to

Other Conditions Chronic rheumatic heart disease, with mitral stenosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-7-46 at ? M.
(b) Where did injury occur? Clifton Park Reservoir
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowned - Reservoir.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/8/46

X

G45399 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83R

Reg. No. 45399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 E. LAKE AVE
(c) Hospital or institution: - AT HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO CO'LY
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 GUILFORD AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA RANDALL LARKIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife WILLIAM H. LARKIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 9, 1867

8. AGE: Years 78 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace NEW YORK CITY, N.Y. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER 12. Name ? — ? — ELLIS

13. Birthplace NOT KNOWN

MOTHER 14. Maiden Name ELIZA CAMPBELL

15. Birthplace NOT KNOWN

16 (a) Informant MRS. C. R. COLLINS (DAUGHTER)

(b) Address 209 E. LAKE AVE., BALTO., MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-46 (month) (day) (year)

(c) Cemetery or crematory LONDON PARK

Location BALTO. - MD.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

NOV 10 1946 (Date received by registrar) (b) Burrington Hillsman, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 8 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1946, to NOV 1946, and that I last saw HER alive on NOV 5 1946.

Immediate cause of death CEREBRAL THROMBOSIS — Duration 2 WEEKS

Due to GENERALIZED ARTERIO-SCLEROSIS — Duration 3 YEARS

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: -

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frederick J. Vollmer M. D.

Address 6100 York Road Date signed Nov 9 1946

X

Physicians: please write the causes of death clearly and legibly. Cause of death is especially important. Please write the correct age.

G45400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45400

Registered No. 1342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Golesville, Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Crowner

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 218-01-9908

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	M

6 (b) Name of husband or wife: Eliza Crowner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-1899

8. AGE: Years	Months	Days	If less than one day
46 47	11	0	hr. min.

9. Birthplace Galesville, Md (Town, county, and state)
10. Usual Occupation Tong Oysters
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Bernard Hardesty
(b) Address Galesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Crowner's
Location Galesville Md

18 (a) Funeral director T A Hardesty & Son
(b) Address Galesville Md

19 1946 (c) Filed by registrar Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1946. 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1946, to 11-10 1946, and that I last saw h/ alive on 11-10 1946.

Immediate cause of death	Duration
Uremia	
Due to Staghorn Kidney Stone (Right)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Jackson M.D. Colored
Address Provident Hosp. Date signed 11-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G45401 BCH 58581 BALTIMORE CITY HEALTH DEPARTMENT G45401
CERTIFICATE OF DEATH 119a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the causes of death clearly and legibly. Space is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 3922 Coltonsville Rd (If rural give location)
(e) Citizen of foreign country? Colborne (Yes or No) If yes, name country

3 (a) FULL NAME Michael Cavey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced Single

6 (b) Name of husband or wife Joseph F Cavey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1946

8. AGE: Years | Months 1 | Days 3 5 4 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Jos. F. Cavey
13. Birthplace Baltomd

MOTHER 14. Maiden Name Dora Morrissette
15. Birthplace Saint Moss

16 (a) Informant Jos. F Cavey
(b) Address 3922 Coltonsville Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore City

18 (a) Funeral director E A Brannagh
(b) Address 2924 Edmondson Ave

19 (a) Date received NOV 14 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Nov 1946, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Oct 1946 to 9 Nov 1946 and that I last saw him alive on 8 Oct 1946.

Immediate cause of death: B Coli meningitis — Duration

Due to Septicemia

Due to

Other Conditions Chloroleukemia Diabetes Hepatitis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebellar Hemorr, Hepatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R E Bauer
Address Univ Hosp Date signed Nov 16 1946 M.D.

G45102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G45102 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4609 White Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4609 WHITE AVE (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country LITHUANIA

3 (a) FULL NAME EVA YOUCH

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOSEPH
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) DEC. 8 - 1895

8. AGE: Years	Months	Days	If less than one day
50	11	-	hr. min.

9. Birthplace LITHUANIA (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name ADAM KALINAOSKAS
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name EVA KICAS
15. Birthplace LITHUANIA

16 (a) Informant Joseph Youch
(b) Address 4609 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Searle W. Hasbrouck
(b) Address 703 McHenry St

Date 11-9-1946 Registrar Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946 at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1929 to Nov. 9 1946
and that I last saw h[illegible] alive on 11-8 1946

Immediate cause of death: Coronary Occlusion — Duration: 1947

Due to: Hypertension & Arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

73. Signature Richard Youch Jr
Address 5707 Belair Rd Date signed 11-9-46

MICHAEL J. GROSSFELD, M.D.

VS 150

G45403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45403 ✓46E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: Sc. Dalto Gen'l Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County:
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 W. Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine May Dixon

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife George Dixon
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 13th 1895

8. AGE: Years 51 | Months 2 | Days 26 | If less than one day: hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name James Hayes
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Crowley
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Huntington Williams, M.D. (Signature of Registrar) Registrar

NOV 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1946 at 6 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1946 to 11-9 1946 and that I last saw ~~he~~ she alive on 11-9 1946.

Immediate cause of death: Acute pulmonary edema
Due to post-operative complications
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: over

Date of operation ~~Autopsy~~ 9-26-46.
Major findings of operation: Obstruction
of autopsy: Path. Chron. Cholecystitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert H. Schindel M.D. M. D.
Address 1211 Light St. Date signed 9-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G45404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd ST.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3245 BEL AIR ROAD.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MARY J. EYLER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	M.

6 (b) Name of husband or wife CHARLES E.
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Sept 30th 1872

8. AGE: Years	Months	Days	If less than one day
74	1	10	hr. min.

9. Birthplace MARYLAND.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOSHUA POOLE.
13. Birthplace MARY LAND.

MOTHER
14. Maiden Name MARGARET PERRY.
15. Birthplace MARYLAND.

16 (a) Informant MRS HILDA RETOVSKY (DAUGHTER)
(b) Address SAME (3245 Belair Rd)

17 (a) Burial (b) Date thereof 11/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received by registrar (b) Arrington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 10, 1946, at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 8 1946 to NOV. 10, 1946, and that I last saw HER alive on Nov. 10, 1946

Immediate cause of death: CARCINOMA, METASTATIC. (PRIMARY SITE UNDETERMINED.) — Duration: 8 MONTHS
Due to
Due to
Other Conditions HYPERTENSIVE CARDIOVASCULAR DISEASE.
(Include pregnancy within 3 months of death)
Date of operation AUG. 24, 1946
Major findings of operation: CARCINOMA METASTATIC LIVER + PERITONEAL CAVITY
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kilpatrick Jr. M. D.
Address Union Memorial Hosp Date signed 11-13-46

VS 150

X

G45105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45105
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 E. 38th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 E. 38th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary K. Yaeger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9-1873

8. AGE: Years 73 | Months 3 2 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name James Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Hannagan
15. Birthplace Ireland

16 (a) Informant Mrs. Marie Carroll
(b) Address 529 E. 38th St.

17 (a) Burial (b) Date thereof Nov. 11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mem. Gdns.
Location Old Frederick Rd.

18 (a) Funeral director John J. Horan
(b) Address 300 E. Baltimore St.

19 (a) (b) by registrar Huntington Williams M.D. Registrar

11 1940

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8- 1946 at 5.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1943 to Nov 8 1946 and that I last saw her alive on Nov 8 1946

Immediate cause of death	Duration
Thrombosis of Right Middle Cerebral Artery	1 day
Due to Pancreatic Organic and Essential Hypertension	4 yrs.
Due to Obesity	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Straughn

Address 10 E. Biddle St. Date signed 11/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G45106
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 270 E. Hilton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 270 E. Hilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perry C. Krauss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1861

8. AGE: Years 85 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Krauss
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Anna Kruesmal
(b) Address 270 E. Hilton St

17 (a) Burial (b) Date thereof Nov. 11 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Henry H. Wetzel
(b) Address 4011 Edmondson Ave

19 (a) (b)
(Date received by registrar) Registrar

NOV 11 1937

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1937 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1937 to Nov 6 1937
and that I last saw h alive on 11/7/37

Immediate cause of death Chronic Myocarditis

Duration

Due to Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilmer J. Gorsuch M. D.
Address 702 Edmondson Ave Date signed 11/8/37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G45407
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley Stankus

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 213-14-0379

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	✓ Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1896

8. AGE: Years	Months	Days	If less than one day
50	9	4	hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Railroad
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Anthony Stankus
(b) Address 637 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balair Rd

18 (a) Funeral director Joseph Kasunskas Sons
(b) Address 602 Washington Blvd

19 (a) (Date received by Registrar) NOV 11 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1946, at 8 50 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull,

Due to

Other Conditions Multiple fract. of ribs, Multiple brush burns.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-8-46 at 8:15 P. M.
(b) Where did injury occur? Philadelphia Rd. and Middle River Road
Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(c) Means of injury Pedestrian Struck by auto.

23. Signature Thomas J. Mercer M.D.
Medical Examiner.
Date signed 11-9-46

VS 191

G45408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45408 Registered No.

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Park Apt. Baltimore Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Henry Irving Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	w	widowed

6 (b) Name of husband or wife Mary Frances Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1866

8. AGE: Years	Months	Days	If less than one day
80	9		hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B & O. R.R.

FATHER
12. Name David Martin
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Berry
15. Birthplace Maryland

16 (a) Informant Mrs. Walter Dandy.
(b) Address 3904 Jungle Rd. Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 11 - 46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams M.D. (Date received by registrar)
(b) NOV 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1946 at 6.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946 to Nov 9 1946 and that I last saw him alive on Nov 9 1946.

Immediate cause of death	Duration
Coronary thrombosis	
Bronchial pneumonia	
Due to Congestive heart failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford F. Rehfuss Jr. M. D.
Address Union Memorial Hosp. Date signed 11-9-46

G45409

G45409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME James Hall Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rachael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1875

8. AGE: Years	Months	Days	If less than one day
70 71	11	28	hr. min.

9. Birthplace Baltimore, Md. (City, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Edward Johnson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Waters
15. Birthplace Howard Co. Md.

16 (a) Informant Richard D. Daly
(b) Address 1433 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Carl H. Hall
(b) Address 1631 Druid Hill Ave

19 (a) Nov 1 1946 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 5 1946, and that I last saw h 18 alive on Nov 1 1946.

Immediate cause of death Lobar Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
S. Signature J. Douglas Sheppard M.D.
Address 1693 Mt Royal Ave Date signed 11/10/46

VS 150

AB-104720 G45410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G45410 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Welford Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3- 1927

8. AGE: Years	Months	Days	If less than one day
19	5	5	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Welford Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Lena Burrell
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-12-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Bonnies Gloucestery Co., Va

18 (a) Funeral director Mrs. Frances H. Hennessy
(b) 11-1946 578 W. Biddle St.

19 (a) Newington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8- 1946, at 5:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23- 1946 to 11-8 1946 and that I last saw h im alive on 11-8 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis Far Advanced	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph H. Bird M. D.
Address Balto City Hosps Date signed 11-9-46

VS 150

X

AB-100255 G45411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45411

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 & 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Matthew Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ada

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10- 1880

8. AGE: Years 65 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Butler (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Mason
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) 1946 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9- 1946 at 12Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1946 to 11-9 1946 and that I last saw h im alive on 11-9- 1946

Immediate cause of death Arteriosclerotic CV Disease — Duration 5 years

Due to Cerebral hemorrhage — 5 years

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roland Hull M.D.
Address Baltimore City Hosp. Date signed Nov 9, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45412 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Abingdon (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA L. BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Charles Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1890

8. AGE: Years	Months	Days	If less than one day
56	1	21	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Pierson
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Lizzie Peaco
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Ida Spencer
(b) Address 1009 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory
Location Mountain, Harford Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1946 at 7:15 P

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5/46 to 11/8/46 19 , and that I last saw h[illegible] alive on 11/8/46.

Immediate cause of death	Duration
Rt lobar Pneumonia	2 days
Due to	
Due to	
Other Conditions Oral Sepsis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H E Welcome M. D.
Address 1101 Harlem Ave. Date signed

VS 150

G45413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G45413 Registered No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Erdman ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Erdman ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charles Schlutter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrye L. Schlutter

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 17-1874

8. AGE: Years 72 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business

FATHER 12. Name John Schlutter
13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Schneider
15. Birthplace Germany

16 (a) Informant Mrs. Carrye L. Schlutter
(b) Address 2220 Erdman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Maggie Cook Lyfer
(b) Address 1600 W. North Ave

19 (a) (Date registered) (b) Registrar Huntington Williams, M.D.

NOV 11 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1946 to 11-8 1946 and that I last saw him alive on 11-8 1946 and that death occurred at the hour stated above.

Immediate cause of death 9:32 A.M. Lobar Pneumonia — 5 days
Due to acute Dilatation of Heart
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2120 W. North Ave Date signed 11-9-46

X

G45414 BALTIMORE CITY HEALTH DEPARTMENT G45414
CERTIFICATE OF DEATH 51B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 S. Charles
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 S Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Edward Wirts
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Emma Neuman
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) May 6, 1879
8. AGE: Years 67 Months 6 Days 4 If less than one day hr. min.
9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Carpenter
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown
16 (a) Informant Mrs Madelene Marling
(b) Address 1318 S. Charles St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd
18 (a) Funeral director John F Henry Inc
(b) Address 28 Light St.
(c) NOV 19 1946 (Date filed by registrar) (d) Huntington Williams

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov. 10th 1946, at 11:15 AM
21. I certify that death occurred on the date above stated; that I attended deceased from June 1914 to Nov. 10 1946 and that I last saw h/ alive on Nov. 9, 1946.
Immediate cause of death Carcinoma of Prostate — Duration
Due to
Due to
Other Conditions Metastases
(Include pregnancy within 3 months of death)
Date of operation 1943
Major findings of operation: Carcinoma of prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward L Levy M.D.
Address 2322 Eastern Pkwy Date signed 11/10/46

VS 150

FORM WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G45115 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Entries must be complete as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 54 E Hill St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 54 E. Hill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Walecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Agnes Bruger
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1860

8. AGE: Years	Months	Days	If less than one day
86	4	11	hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Cecelia Walters
(b) Address 54 E. Hill St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director John F Henry Inc
(b) Address 718 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 13 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/46 19.. at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1946 to Nov 10 1946 and that I last saw deceased alive on Nov 9 1946

Immediate cause of death Chronic
Myocarditis -
arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Schneider M. D.
Address 1111 W Lee Date signed 11/11/46

X

G45416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45416 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Burgundy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Burgundy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Clarke

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-03-334

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C. C.	Married

6 (b) Name of husband or wife Catherine Clarke
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 1/8/1882

8. AGE: Years	Months	Days	If less than one day
57	11	3 29	hr. min.

9. Birthplace Sumter S. C. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Edward Clarke
13. Birthplace S. C.

MOTHER 14. Maiden Name Lucy Wilson
15. Birthplace S. C.

16 (a) Informant Fairfax Clarke
(b) Address 1114 Leadenhall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto City

18 (a) Funeral director Frank L. Brandau
(b) Address 108 N. Montgomery St.

19 (a) Date received by registrar NOV 11 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1946 (Month) (Day) (Year)

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946 to Nov. 7 1946; and that I last saw h alive on Nov. 7 1946.

Immediate cause of death: Chronic Valvular Heart Disease — Duration 6 Months
Due to Hypertension — Duration 1 year
Due to Chronic Nephritis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Langdon Gholston M.D.
Address 905 S. Bway Date signed 11/10/46

Huntington Williams, M.D.

G45117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 94a

G45117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Erastamus Ober Jr.

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 215-10-1664

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Beatrice Barclay Ober
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 4 1880

8. AGE: Years 66 | Months 4 | Days 6 | If less than one day: ____ hr. ____ min.

9. Birthplace Baltimore, Baltimore Md (Town, county, and state)
10. Usual Occupation Insurance executive
11. Industry or business Public Utility & Depost

FATHER
12. Name Mr Robert Ober
13. Birthplace Maryland

MOTHER
14. Maiden Name Rosa Woolfolk
15. Birthplace Georgia

16 (a) Informant Mrs Beatrice Barclay Ober
(b) Address Lutherville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md

18 (a) Funeral director Henry N. Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) ____ 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1946, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1946, to Nov 10 1946, and that I last saw h[illegible] alive on 11-9 1946

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kidd Jr. M. D.
Address Union Memorial Hosp. Date signed 11-10-46

X

G45418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45418 Registered No. 43a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address GREENE & LOMBARD STS.
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE REDDICK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife DAVID
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 4/1/1898

8. AGE: Years 48 | Months 7 6 | Days 6 | If less than one day hr. min.

9. Birthplace Greenville, S.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Pool
13. Birthplace Greenville, S.C.

MOTHER
14. Maiden Name Anna Roster
15. Birthplace Greenville, S.C.

16 (a) Informant David Reddick (Husband)
(b) Address 1711 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/1946 (month) (day) (year)
(c) Cemetery or crematory WESTERN STAR Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave

NOV 11 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 7, 1946, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1946 to 11-7 1946 and that I last saw her alive on 11-7 1946.

Immediate cause of death: Respiratory Paralysis. — Duration

Due to Subarachnoid hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Boorhaman M. D.
Address Univ. Hosp. Date signed 11-7-46

VS 150

X

Dr. Deikel
1226 Hanover

G35119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

G35119
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 E. Lafayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 6
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 E. Lafayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Elizabeth Gallion

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George E. Gallion
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 187?

8. AGE: Years	Months	Days	If less than one day
69	1	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name John H. Moore
13. Birthplace ?

MOTHER 14. Maiden Name ? Brittingham
15. Birthplace ?

16 (a) Informant Mrs. Mae Snow
(b) Address 1609 E. Lafayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 11 1946 (b) Registered by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1946 to Nov. 8 1946 and that I last saw her alive on Nov. 8 1946.

Immediate cause of death Acute heart failure - hypertensive kardio vascular disease — Duration 2

Due to

Due to

Other Conditions Carcinoma of rite Kidney — Duration 2
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deikel. M.D.
Address 1226 Hanover St Date signed 11/10/46

VS 150

G45420 BALTIMORE CITY HEALTH DEPARTMENT G45420

CERTIFICATE OF DEATH 195E

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 W. Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES M. CALLAHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1931

8. AGE: Years	Months	Days	If less than one day
15	6	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation UnKown
11. Industry or business

FATHER
12. Name Joseph Callahan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Beatrice Anders
15. Birthplace Baltimore

16 (a) Informant UnKown
(b) Address "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Catheolral
Location

18 (a) Funeral director Loving Byers
(b) Address 5005 Park Heights Ave

19 (a) NOV 14 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1946, at 11.47 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-10-46 at 3 P. M. Cattr. Co.
(b) Where did injury occur? Old Court Rd. Pikesville
(c) Did injury occur at home, on farm, industrial place, in public place? Farm While at work? No
(d) Means of injury Struck by horse pulling manure sled.

23. Signature Howard J. Mackie M.D.
Medical Examiner.
Date signed 11-11-46

X

G45421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G45421
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 George St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 George St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda A. Langford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George P. Langford

6 (c) If div., give age Years

7. Birth date of deceased (mo., day, yr.) Dec. 1882

8. AGE: Years 63 | Months 11 | Days | If less than one day: hr. min.

9. Birthplace Somerset Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Handy
13. Birthplace Md. ?

MOTHER
14. Maiden Name Violet ?
15. Birthplace Md.

16 (a) Informant Sadie Gardner
(b) Address 624 George St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory W. Arlington Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) Date received by registrar Nov 14 1946 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1946 at 2 P M

21. I certify that death occurred on the date above stated, that I attended the deceased from Nov 10 1946 to Nov 12 1946 and that I last saw h[illegible] alive on Nov 7 1946.

Immediate cause of death: Cerebral hemorrhage — Duration 2 d

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.

Address 74 E Eager St Date signed 11/14/46

VS 150

G45422 ✓ G45422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: University Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County _____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Fairfield Road. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME Anna nee Becker Borne

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Walter Borne
6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) 2[illegible] July 1921

8. AGE: Years 25 | Months 3 | Days 17 | If less than one day hr. _____ min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Otto Becker
13. Birthplace Maryland

MOTHER
14. Maiden Name Sophie Koglowski
15. Birthplace Poland

16 (a) Informant Walter Borne
(b) Address 3617 Fairfield Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanslaus
Location Balto. Md.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave
(c) [illegible] (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

NOV 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 November 1946, at 2[illegible] 36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to 8 Nov 1946 and that I last saw her alive on 8 Nov. 1946.

Immediate cause of death Eclampsia — Duration 9 days
Due to _____
Due to _____
Other Conditions Pregnancy, 32 wks. over
(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton J. Miller M.D.
Address Univ. Hosp., Balto., Date signed 11-8-46

Do not write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

VS 8

X

G45123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G45123 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 918 Shields place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hester Annie Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Married

6 (b) Name of husband or wife Leon Chambers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52 yrs			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Pierce
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Jones
15. Birthplace Md.

16 (a) Informant Leon Chambers
(b) Address 918 Shields place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Asbury Cem.
Location Fairlee Kent Co. Md

18 (a) Funeral director Metropolitan Fun. Home Inc.
(b) Address 927 N. Mount St.

19 (a) NOV 11 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8- 1946. at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-1946. to 11-8-1946
and that I last saw her alive on 11-8- 1946.

Immediate cause of death: Reticulum cell sarcoma — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 11-10-46

G45424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

G45424 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 S. Potomac St # 24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alvecta Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	Colored	married

6 (b) Name of husband or wife John H Gray. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6 1913

8. AGE: Years	Months	Days	If less than one day
33.	10.	5.	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House-Wife

11. Industry or business

FATHER
12. Name Carl Scarlora
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Rose Oder
15. Birthplace Baltimore Md.

16 (a) Informant John H Gray
(b) Address 715 S. Potomac St

17 (a) Burial (b) Date thereof Nov [illegible] 1946
(Burial, cremation, or removal) (month) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Road

18 (a) Funeral director Rendall & Rippel
(b) Address 312 S. Highland Ave

19 (a) (b) Washington Williams, Registrar
(Date rec'd by Local Registrar)
NOV 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946, at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1946, to Nov. 8 1946, and that I last saw her alive on Nov. 8 1946.

Immediate cause of death	Duration
(a) Pre-eclamptic toxemia of pregnancy	2 wks.
Due to (b) Premature separation of placenta	7 1/2 hrs.
Due to (c) Intrapostpartum shock.	7 1/2 hrs.
Other Conditions Pulmonary edema	1 hr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kevirt

Address Sinai Hospital Date signed 11/8/46 M. D.

X

G45425 Taldon ✓ G45425

G45425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

Every item of information should be carefully supplied. The space for "Usual Residence" is especially important. Physicians—please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 529 N. Carrollton Ave 18

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 529 N. Carrollton Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME Charles Garfield Taldon 20p

MEDICAL CERTIFICATION

3 (b) If veteran, name war None

3 (c) Social Security Account No. ??

20. DATE OF DEATH 11/9 1946 at 3 M

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/26/1899

8. AGE: Years 47 Months 7 Days 14 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John C. Taldon

13. Birthplace Maryland

MOTHER 14. Maiden Name Hattie Brown

15. Birthplace Maryland

16 (a) Informant Elizabeth Taldon

(b) Address 529 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)

(c) Cemetery or crematory Aberdeen

Location Aberdeen Maryland

18 (a) Funeral director Geo. D. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

11 1946

VS 190

21. I certify that death occurred on the date above stated, that I attended deceased from 9/2 1946 to 9/11 1946 and that I last saw him alive on 11/9 — 1946.

Immediate cause of death Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Benj R Leitch M.D.

Address 213 Dumbarton Rd Date signed 11/15/46

G45126 ✓ G45426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution. Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mirra Rubenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Chava

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — | 1861

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

FATHER
12. Name Laib —
13. Birthplace Russia

MOTHER
14. Maiden Name Tobie —
15. Birthplace Russia

16 (a) Informant Chava Rubenstein
(b) Address 224 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-46 (month) (day) (year)
(c) Cemetery or crematory Shaw Mt. Carmel
Location

18 (a) Funeral director Isadore Levin Inc
(b) Address 1939 E. Balto. St

(c) Filed by registrar Huntington Williams M.D.
NOV 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1946, at 10 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946, to Nov 10 1946 and that I last saw h alive on Nov 10 1946

Immediate cause of death Pulmonary edema — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions Pulmonary emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Heinz Beissinger M.D.
Address Sinai Hospital Date signed Nov. 11 1946 M. D.

VS 150

G45427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G45427
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Cookie St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Bookcie St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Krupinski

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Paul Krupinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1867

8. AGE: Years	Months	Days	If less than one day
79	6	5	hr. min.

9. Birthplace Poland.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Stella Wojcik.
(b) Address 1212 Bookcie St.

17 (a) Burial (b) Date thereof 11-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Kelly F. Dill
(b) Address 1531 E. Fort Ave.

19 (a) 11-9-46 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-46, at 6 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-1-46 to 11-8-46 and that I last saw h[illegible] alive on 11-7-46

Immediate cause of death	Duration
Cardiac thrombosis	3 days
Due to Bronchitis	1 wk
Due to Arteriosclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 11-9-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G45128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1456 Stevenson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1456 Stevenson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Miller

3 (b) If veteran, name war: World War – 1

(c) Social Security Account No. 214-03-7044

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva Miller

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Nov 12th 1882

8. AGE: Years 57 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Hungary. (Town, county and state)

10. Usual Occupation Iron Worker.

11. Industry or business

FATHER
12. Name Frank Miller.
13. Birthplace Hungary.

MOTHER
14. Maiden Name Elizabeth Hanes.
15. Birthplace Hungary.

16 (a) Informant Eva Miller.
(b) Address 1456 Stevenson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Chas. T. Hill
(b) Address 1621 E. Fort Ave.

19 (a) (Date sold by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-46 19 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1946 to 11-8 1946 and that I last saw h alive on 11-8 1946

Immediate cause of death: Acute Cardiac Failure — Duration 1 Day

Due to: Hypertensive Cardio Vascular Renal Disease — Duration Yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work?)
(e) Means of injury

23. Signature Lloyd G Lowe Coroner
Address 1679 Washington Blvd Date signed 11/11/46

VS 150

G45429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G45129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 Whitridge (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mariano Grimaldi

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-9409

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Antonietta

6 (b) Name of husband or wife Antonette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/19

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Kitchen Work

11. Industry or business Miller Bros. Restaurant

FATHER
12. Name Domenico Grimaldi
13. Birthplace Calascibetta Italy

MOTHER
14. Maiden Name Michelina Russo
15. Birthplace Calascibetta Italy

16 (a) Informant Louis J. Rindone (Nephew)
(b) Address 2833 Millen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 1 N. Morley St.

19 NOV 12 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/46 19 12:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1946 to 11/11 1946
and that I last saw him alive on 11/10 1946

Immediate cause of death — Duration

Uremia.

Due to Obstructive Jaundice

Due to Carcinoma of Pancreas + Liver ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Feeney M.D.
Address St. Joseph's Hosp. Date signed Nov. 12 46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Reg. No. G45130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Penrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Penrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. BALLING

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I & 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Loeblein Balling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1881

8. AGE: Years	Months	Days	If less than one day
65	6	0	hr. min.

9. Birthplace Rothenbuchen, Germany
(Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Standard Oil Co.

FATHER
12. Name August Balling
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Mrs. Anna L. Balling
(b) Address 2202 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md. Williams, M.D.

19 NOV 17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9. 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to NOV 9 1946 and that I last saw h[illegible] alive on Nov 8 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	12 hrs.
Due to Intramural Leiomyoma Cervix Uteri	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elinor Longfellow M.D.
Address 402 W. Jayson St. Date signed 11/9/46

VS 150

G45131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Reg. ~~G45131~~ 45131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 Gittings Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Gittings Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME REBA M. QUINN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James J. Quinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 24, 1885

8. AGE: Years	Months	Days	If less than one day
60	10	15	hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Harry Beirhalter
13. Birthplace Lockhaven, Pa.

MOTHER 14. Maiden Name Mary Gilbert
15. Birthplace Phila. Pa.

16 (a) Informant Mr. James J. Quinn
(b) Address 405 Gittings Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams, M.D. (b) Registrar
(Date received by Registrar) NOV 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1946 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Oct. 1946 to 9 Nov. 1946, and that I last saw h[illegible] alive on 8 Nov. 1946.

Immediate cause of death	Duration
Coronary thrombosis	6 hrs.
Due to Coronary sclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Wise M.D.
Address 920 St. Paul St. Date signed 10 Nov. '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Reg. No. G45432

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Oakhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Oakhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORA BARTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter J. Barton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1869

8. AGE: Years	Months	Days	If less than one day
76	10	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Houseduties
11. Industry or business

BOTHER'S FATHER
12. Name - Fitchette
13. Birthplace Unknown

BOTHER'S MAIDEN
14. Maiden Name -
15. Birthplace -

16 (a) Informant Mrs. Bessie Tobin
(b) Address 3005 Oakhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) NOV 12 1946 (Date rec'd by Registrar) (b) Huntington Hollins, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1946, to Nov. 9 1946 and that I last saw her alive on Nov. 5 1946.

Immediate cause of death Coronary Thrombosis — Duration 18 Days.
Due to
Due to
Other Conditions Systemic Sclerosis & Hypertensive Heart
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: -
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl L. Chambers, M. D.
Address 4108 Liberty Hts. Date signed 11-7-46

X

G45133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

G45133 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d + Calvert Sts
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Simpson St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE GINSBERG

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Morris Ginsberg.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) [illegible] 2/?/1883

8. AGE: Years	Months	Days	If less than one day
63	9	?	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Lloyd Schuster
13. Birthplace Russia

MOTHER
14. Maiden Name Zalda Schuster
15. Birthplace Russia

16 (a) Informant Morris Ginsberg
(b) Address 2401 Simpson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12/46 (month) (day) (year)
(c) Cemetery or crematory Maryland Lodge Cemetery
Location Hamilton Ave & Rosedale
18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave
19 (a) Filed NOV 12 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1946 at 7 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1946 to 11/11 1946 and that I last saw h[illegible] alive on 11/11 1946

Immediate cause of death: Cardiac Arrest — Duration: 3d

Due to Intestinal Obstruction — ?

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Union Mem Hosp Date signed 11/14/46

VS 150

X

G45434 4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G45434

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Wilkens ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walther Carl Horn

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9356

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Magdalena Horn nee Dittmar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23 - 1905

8. AGE: Years	Months	Days	If less than one day
41	9	16	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Charles Horn
13. Birthplace A. A. Co. MD.

MOTHER
14. Maiden Name Alice V. Fowler
15. Birthplace Md.

16 (a) Informant Mrs. Magdalena Horn
(b) Address 2108 Wilkens Ave.

17 (a) Burial (b) Date thereof Nov. 12 - 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Essex

19 NOV 12 1946 (b) Registrar
(Date received by local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th 1946, at 8:30 A. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45435 2

BALTIMORE CITY HEALTH DEPARTMENT X 937

CERTIFICATE OF DEATH

Registered No. G45435

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Monroe St.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Long Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. Choptank Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clavell, George Edward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Loretta Clavell nee Gerbler
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 3-24-1890

8. AGE: Years	Months	Days	If less than one day
62	7	15	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER 12. Name George Clavell
13. Birthplace Md.

MOTHER 14. Maiden Name Emma Sachs
15. Birthplace Md.

16 (a) Informant Mrs Loretta Clavell
(b) Address Long Beach, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-46 (month) (day) (year)
(c) Cemetery or crematory Ebenezer, Location Chase Md.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Balto

19 (a) Date received by registrar 11-13-46 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1946, at 3 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7, 1946 to Nov. 9, 1946, and that I last saw him alive on Nov. 9, 1946.

	Duration
Immediate cause of death Cardio-vascular-respiratory paralysis	
Due to Cerebral Hemorrhage	2 days
Due to Hypertensive Cardio-vascular disease	10 years (?)
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry C. Hitch M.D.
Address University Hosp. Date signed 11/5/46 M. D.

VS 150

G45136 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55c

Registered No. G45436

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Wolf

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-9412 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-71

8. AGE: Years	Months	Days	If less than one day
75	2	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Wolf

13. Birthplace Maryland

MOTHER 14. Maiden Name Jenny Fraker

15. Birthplace Maryland

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location O'Donnell St.

18 (a) Funeral director John B. Connelly

(b) Address 418 Eastern Ave. City

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1946, at 4 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1946, to 11-7 1946, and that I last saw h alive on 11-7 1946.

Immediate cause of death Cerebral Embolus? Duration Few Mins.

Due to Post Op. Carcinoma?

Due to Weakening in Hypopharyngeal cyst.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Extensive Carcinoma (squamous) a

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Date signed 11/8/46

VS 150

G45137
AB-105941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G45137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 East Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Hamilton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7- 1904

8. AGE: Years	Months	Days	If less than one day
42	4	3	hr. min.

9. Birthplace ? Norristown, Pa. (Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business

FATHER
12. Name ? Charles Sumner
13. Birthplace ? Virginia

MOTHER
14. Maiden Name ? Gertrude Wilson
15. Birthplace ? Norristown, Pa.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-46 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Philadelphia, Pa.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 (a) 11 12 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10- 1946, at 11.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8- 1946 to 11-10 1946, and that I last saw h im alive on 11-10 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	1 day
Due to	
Other Conditions Hypertension Cardiovascular Renal (Include pregnancy within 3 months of death)	yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 11/13/46

VS 150

G45438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G45438 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Pl.
(c) Hospital or institution: "Elmhurst Home"
(d) Length of stay in hospital or inst. (yrs., mos., or days) about 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Pl
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Gavin

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary Gavin
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 24 1862

8. AGE: Years	Months	Days	If less than one day
84	8	20	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Maisin Gavin
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary —?—
15. Birthplace Ireland

16 (a) Informant Mary Gavin (daughter)
(b) Address 6426 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12 '46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Sheehan Mortuary Co.
(b) Address 1084 W North Ave.

NOV 12 1946
(a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1946 about 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov. 9 1946 and that I last saw him alive on Nov. 9 1946

Immediate cause of death Coronary Thrombosis — Duration

Due to Advanced atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Louis Francis
Address 1700 Eutaw Pl. Date signed Nov. 11 '46 M. D.

X

G45139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G45139 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere / Park Heights
(c) Hospital or institution: Pimlico Race Track
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles 9 33 St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Otho Stobbs

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: May B. Stobbs
6 (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) Feby 28 1879
8. AGE: Years 67 | Months 8 | Days 12 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore Md.
(Town, county and state)
10. Usual Occupation Merchant
11. Industry or business (Sea Food)
FATHER 12. Name Andrew J. Stobbs
13. Birthplace Balto. Md.
MOTHER 14. Maiden Name Matilda Hurst
15. Birthplace Balto. Md.
16 (a) Informant Mrs May B Stobbs (wife)
(b) Address Charles & 33 St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-12-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.
18 (a) Funeral director Stewart & Mooney Co.
(b) Address 1084 W Mt. St.
19 (a) NOV 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/46 19 ____, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 11/10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G45140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G45140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 145 S. Calverton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 145 S. Calverton Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Stricker

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 29, 1866

8. AGE: Years 80 | Months 9 10 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Stricker
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Brady
15. Birthplace Ireland

16 (a) Informant Margaret Stricker
(b) Address 145 S. Calverton Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-46 (month, day, year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

19 (a) (Date received by registrar) by telephone from Williams Mortuary (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1946, at 10:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1946 to Nov. 1946, and that I last saw h alive on Nov 10 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to Arteria-sclerotic Cardia vascular
Due to Senile
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D. Clyde Langston M. D.
Address 400 N. Payson St. Date signed 11/16/46

X

G45141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V33a

G45141 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2233 Ramsay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 Ramsay Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta T. Pritchard

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Lester A. Pritchard
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 12-10-1882

8. AGE: Years	Months	Days	If less than one day
63 64	11	—	hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name ? Berg
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Edgar P. Graham
(b) Address 2233 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George L. Schwatt
(b) Address 2101 Frederick Avenue

19 (a) (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1946, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1946 to Nov 10 1946, and that I last saw h[illegible] alive on Nov 9 1946

Immediate cause of death

	Duration
Bronchitis	2 days
Due to Influenza	12 days
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. [illegible] M. D.
Address 176 Bolton St. Date signed Nov 11 46

G45442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

Registered No. G45442

No. 105943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August Ehlser Michaelis

3 (b) If woman, name was None

3 (c) Social Security Account No. 705-03-5344

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. (Separated) Married

6 (b) Name of husband or wife: Loretta Michaelis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8th 1886

8. AGE: Years	Months	Days	If less than one day
59	11	1	hr. min.

9. Birthplace Maryland

10. Usual Occupation Sheet Metal Worker

11. Industry or business Roofing Co

FATHER
12. Name Herman Michaelis (D
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah Comreder
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Raff & B. M. Walter
(b) Address Pratt & Eutaw Sts
(c) NOV 12 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9th 1946 at 5.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8th 1946 to Nov. 9th 1946 and that I last saw him alive on Nov. 9th 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Embolism	2 wks ?
Due to Thrombophlebitis, Lt Leg.	2 weeks ?
Other Conditions Hemoplegia, Lt.	2 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edmund B. Beaelsan
Address Balto City Hosp Date signed 10 Nov 46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45443 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Old Spring Lane
(c) Hospital or institution: Elkins Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1053 W. Fayette St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Rothel

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles F. Rothel
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): February 8, 1860
8. AGE: Years 86 | Months 9 | Days 1 | If less than one day: hr. min.
9. Birthplace: Alexandria, Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: James Cole
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Virginia

16 (a) Informant: Wilmer M. Cole
(b) Address: 2039 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore, Maryland

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1946, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-15 1946, to Nov 9 1946, and that I last saw her alive on Nov 9 1946.

Immediate cause of death: ARTERIO-SCLEROTIC HEART DISEASE. — Duration: 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Klamman M. D.
Address 3803 Edmondson Ave. Date signed 11/9/46

VS 150

G45144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 Coolidge Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATILDA B. SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife William C. Schmidt

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 25, 1893

8. AGE: Years 53 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Emil Koch

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Marie Reich

MOTHER 15. Birthplace Germany

16 (a) Informant George Schmidt

(b) Address 3519 Coolidge ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12 1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Hudgnick & Dole

(b) Address 1200 W. Lombard St.

19 (a) NOV 12 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/46 19 , at 9 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Lewis, M.D. Medical Examiner.
Date signed 11/10/46

VS 151

Type or write in ink. Every item must be answered. If unknown, write unknown. Do not abbreviate. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

168 G45445

Registered No.

Boarded: 1700 Thames Street.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio [illegible] Ameiros

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1881

8. AGE: Years 65 | Months 2 | Days | If less than one day: hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Merchant Marine

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant J. Muniz
(b) Address 800 S. Broadway

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM.
Location GERMAN HILL RD, DUNDALK

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 405 S. WOLFE ST.

19 (a) NOV 12 1946 (b) Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1946, at 6.25 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to 2nd & 3rd degree burns.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-46. 4.30 a. M.
(b) Where did injury occur? 1700 Thames St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Explosion - fire.

23. Signature Howard J. Ulleseis M.D.
Medical Examiner.
Date signed 11-11-46

X

G45146 — BALTIMORE CITY HEALTH DEPARTMENT — G45146

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Preston & St Paul
(c) Hospital or institution: (Home) East Court Apt. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St Paul & Preston (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Rebecca Hurst Smith

3 (b) If veteran, name war — No
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Granville Smith
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) Aug-29-1877
8. AGE: Years 69 Months 2 Days 13 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name John J Hurst
13. Birthplace Md.

MOTHER
14. Maiden Name Martina A. Webster
15. Birthplace Md.

16 (a) Informant Granville Smith (Husband)
(b) Address East Court Apts —
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-13-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn
18 (a) Funeral director Sawyer & Moomau
(b) Address 108 W Monument
19 (a) Date rec'd by registrar NOV 12 1946 (b) Registrar Hunter Williams M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11th 1946, at 3:50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1946 to Nov 11th 1946, and that I last saw him alive on Nov 11th 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 weeks
Due to Arterio Sclerosis	
Due to Hypertension	
Other Conditions Myocardial Degeneration	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
Autopsy? No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature J. A. Chilcoat M. D.
Address 500 E. Cold St Date signed Nov 14 1946

83a

G45147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G45147
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Bateman
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Battolety
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Bateman Av
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Howard Appleby

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wm. L. Appleby
6 (c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.) Jan-20-1876

8. AGE: Years 70 | Months 9 | Days 21 | If less than one day: hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name M. Tilghman Howard
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Harriet N. Wood
15. Birthplace A. A. Co. Md.

16 (a) Informant: Mr. J. A. Appleby Jr. son
(b) Address 4701 Gonbel Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Money Co.
(b) Address 108 W Lexington St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 158 NOV 12 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1946 at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from several years 19 to 19 ; and that I last saw h[illegible] alive on Nov. 10 1946

Immediate cause of death
Cardiac Syncope
Due to Cerebral Hemorrhage
Due to Arteria Sclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Duration of Illness
10 hrs
several years

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Lakeside Ewell M.D.
Address 2945 St. Paul St Date signed Nov 11/46

X

G45148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G45148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4138 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4138 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence V. Miller

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 13th 1859

8. AGE: Years 87 | Months 5 | Days 27 | If less than one day: hr. min.

9. Birthplace Aberdeen, Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business At Home

FATHER
12. Name Benjamin H. Miller
13. Birthplace Rock Hall, Md.

MOTHER
14. Maiden Name Mary Ann Numbers
15. Birthplace Aberdeen Md.

16 (a) Informant Mrs. S. E. Garrett
(b) Address 1212 W. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/46 (month) (day) (year)
(c) Cemetery or crematory Cradburg
Location Perrymans, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 12 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10th 1946, at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 10 1946 and that I last saw h. alive on Nov 10 1946.

Immediate cause of death	Duration
Acute myocardial insufficiency	2 days.
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J Daines M. D.
Address 800 W 32nd St Date signed 11-11-46

VS 150

X

G45449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. G45449

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE 17. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1843 LORMAN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLE MATTHEWS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-1-1901

8. AGE: Years 45 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Athens, Ga. (Town, county, and state)

10. Usual Occupation DOMESTIC

11. Industry or business

FATHER 12. Name Lucious Colquit

13. Birthplace Ga.

MOTHER 14. Maiden Name MARY ~~Hayth~~ Colquit

15. Birthplace Ga.

16 (a) Informant MAUD HAYTH

(b) Address 1843 LORMAN ST

17 (a) SHIPPED (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)

(c) Cemetery or crematory CLARKE-COUNTY

Location ATHENS-GEORGIA.

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

NOV 12 1946 (Date rec'd by Registrar) ~~Washington~~ Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-46 19 at 4:P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7- 1946 to 11-8 1946 and that I last saw h[illegible] alive on 11/8 1946

Immediate cause of death: Cardiorespiratory failure — Duration c

Due to: Tuberculosis — TUBERCULOSIS

Due to: Pneumonitis — PNEUMONITIS

Other Conditions: Hemoptysis (0C022)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Mills M.D.

Address Pt Jos Hosp Date signed 11-9-46

VS 150

X

G45150 BALTIMORE CITY HEALTH DEPARTMENT G45150

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 W. HAMBURG. ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V'
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 W. HAMBURG. ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELSIE PORTER. (TYLER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race COLORED. | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ISIAH

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-4-1908

8. AGE: Years	Months	Days	If less than one day
38	7	5	hr. min.

9. Birthplace BALTIMORE Md. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name CHARLES TYLER

13. Birthplace Va

MOTHER 14. Maiden Name MARY PARK

15. Birthplace Md

16 (a) Informant NAOMI BANKS.

(b) Address 419 W. HAMBURG ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 2 46 (month) (day) (year)

(c) Cemetery or crematory MT. CALVARY CEM.

Location A. A. COUNTY - Md.

18 (a) Funeral director WILLIAM A JACKSON.

(b) Address 916 PENNA. AVE.

19 (a) NOV 12 1946 (Date received by Registrar) Thurlington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1946, at 12 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1945 to Nov 9 1946, and that I last saw h[illegible] alive on Nov 7 1946

Immediate cause of death: Cardiac Insufficiency — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. D. Watts M. D.

Address [illegible] Date signed 11-9-46

V S 150

G45151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1270

Registered No. G45151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Hinke.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Alfred Hinke
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1881

8. AGE: Years 64 | Months 10 | Days 27 25 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name George W. Biddison
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Fink
15. Birthplace Md.

16 (a) Informant Mr. Alfred Hinke
(b) Address 1824 N. Washington St.

17 (a) Burial (b) Date thereof 11/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location Eastern ave.

18 (a) Funeral director Howard V. Bligh Jr
(b) Address 4946 Belair Road

19 (a) NOV 12 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Nov 1946, at 8 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Nov 1946 to 8 Nov 1946, and that I last saw her alive on 8 Nov 1946.

Immediate cause of death Acute Coronary attack. — Duration

Due to

Due to

Other Conditions Post-op. cholecystectomy Hypertensive C-V Disease
(Including pregnancy within 3 months of death)

Date of operation 8 Nov 46

Major findings of operation: Cholecystitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard H. Pat
Address Sinai Hospital Date signed 9 Nov 46

VS 150

G45152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1112

G45152 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2822 Parkwood Ave
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose L Fribush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Riga
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Abraham Baer
13. Birthplace Riga

MOTHER
14. Maiden Name Sarah Ella Cantor
15. Birthplace Riga

16 (a) Informant Henry Fribush
(b) Address 2652 Oswego Ave

17 (a) Burial (b) Date thereof Nov. 12, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received by registrar NOV 12 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1946 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Nov. 12 1946 and that I last saw h[illegible] alive on Nov. 11, 1946.

Immediate cause of death: Acute Pulmonary Edema — Duration: 6 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Goppelt M. D.
Address 701 W Baltimore St Date signed NOV 12 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45153 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE, 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. HOMEWOOD APARTMENTS (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCHE HAUSER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 28, 1878

8. AGE: Years 67 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name G. S. HOWSER
13. Birthplace MARYLAND

MOTHER
14. Maiden Name CECELIA BRAMWELL
15. Birthplace MARYLAND

16 (a) Informant DECEASED
(b) Address Homewood Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1901 Eutaw Place

19 (a) NOV 12 1946 Registered (b) Received, M

VS 150

Huntington Hillman, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1946, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1946 to Nov 10 1946, and that I last saw HER alive on NOV 10 1946.

Immediate cause of death: Coronary Occlusion — Duration: 5 Days

Due to: Arteriosclerotic cardio-vascular disease — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas G. Young M. D.
Address Union Memorial Hospital Date signed Nov 10, 1946

X

G45454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G45454 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 N. Caroline st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Colvin st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-11-1896

8. AGE: Years	Months	Days	If less than one day
50	9 10	9 29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name John Francis Burke
13. Birthplace Baltimore. Md.

MOTHER
14. Maiden Name Maggie Wilson
15. Birthplace Baltimore. Md.

16 (a) Informant Matilda Kendell
(b) Address 613 N. Caroline st

17 (a) Burial (b) Date thereof Nov. 13-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore. Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson St.

19 (a) (b)
(Date received by local registrar) (Registrar)

NOV 12 1946

Huntington Hilleary, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1946, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3- 1946 to 11-9- 1946, and that I last saw h[illegible] alive on 11-9- 1946.

Immediate cause of death
Lobar Pneumonia — Duration 12 days

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H. Cargiss M. D.
Address 611 N. Caroline st Date signed 11-12-46

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45455 122a Registered No. G45455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood & Greene Sts
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Catonsville Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Spruce St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Uriesin Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Margaretta Uriesin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14-1894

8. AGE: Years	Months	Days	If less than one day
52	2	25	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Boilermaker
11. Industry or business

FATHER 12. Name John Walter Uriesin
13. Birthplace Austria

MOTHER 14. Maiden Name Barbara Balik
15. Birthplace Austria

16 (a) Informant John Walter Uriesin Jr
(b) Address 4107 Audrey Ave (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St - 25-

19 (a) (Date rec'd by registrar) (b) Registrar

VS NOV 12 1946 Kentington for Nottingham, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1946 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1946 to 11/9 1946 and that I last saw him alive on 11/9 1946.

Immediate cause of death Cardio-respiratory failure
(a) Myocardial destruction
Due to Hypertension
(b) Arterial sclerosis
Due to
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph L Trachtes M. D.
Address Union Hosp., Date signed 11/10/46

G45456

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G45456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 South Decker Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 South Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bronislawa Godzik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Andrzej

6 (c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): Dec, ? 1870

8. AGE: Years: 75 Months: 11 Days: If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Andrew Rachuba
13. Birthplace: Poland

MOTHER
14. Maiden Name: Karolina ?
15. Birthplace: Poland

16 (a) Informant: Mrs. Elizabeth Kujawa
(b) Address: 641 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-46 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Baltimore, Md.

18 (a) Funeral director: George A Weber
(b) Address: 705 South Ann Street

19 (a) Nov 12 1946 (b) Registrar's signature: Huntington Williams, M.D.

V2 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11th 19 46, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 19 46 to Nov 11 19 46 and that I last saw h[illegible] alive Nov 11 19 46

Immediate cause of death: Coronary Occlusion — Duration 4 days

Due to Chr Myocard. Deg — July 1946

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William J Rosario M.D.
Address: 801 Kenwood Ave Date signed 11/12/46

G45457 HEALTH DEPARTMENT—CITY OF BALTIMORE G45157

CERTIFICATE OF DEATH 1832

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 510 N. CHAPEL St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. If of foreign birth 62 yrs. mos. ds.

2. FULL NAME ANNIE RUSSY REZEK — If U. S. Veteran specify WAR

(a) Residence: No. 510 N. CHAPEL St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	White	WIDOW.

5a. If married, widowed, or divorced (or) WIFE of JAMES W. REZEK

6. DATE OF BIRTH (month, day, year) April ? 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	7?	?	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 18

12. BIRTHPLACE (city or town) (State or country) Cesk Czechoslovakia

FATHER

13. NAME FERDINAND RUSSY

14. BIRTHPLACE (city or town) (State or country) CZECHOSLOVAKIA

MOTHER

15. MAIDEN NAME SOPHIA ?

16. BIRTHPLACE (city or town) (State or country) CZECHOSLOVAKIA

17. INFORMANT Family
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Oak Hill Cem. Date 11/13 1946

19. UNDERTAKER Philip Herwig Sons
(Address) 2024 Eutaw St.

20. FILED NOV 12 1946 Register

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 10, 1946

22. I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1946 to Nov. 10, 1946

I last saw her alive on Nov. 9, 1946 Death is said to have occurred on the date stated above, at 7 30 A.m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
Cerebral Hemorrhage	7 days

Other contributory causes of importance:
Hypertensive Vascular Disease
Arteriosclerosis

Was an operation performed? No Date of

For what disease or injury?

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) Ferd. E. Kadan M. D.

(Address) 15 W Mt Vernon Place

Ferd E. Kadan x

V8 8

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G45158
AB-10 8851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12B

Registered No. G45158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 & 26days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 687 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16- 1923

8. AGE: Years	Months	Days	If less than one day
23	2	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Adams
13. Birthplace ?

MOTHER
14. Maiden Name Anne Reid
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 NOV 12 1946 Huntington Williams M.D.
(Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1946, at 1:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1946 to 11-9 1946 and that I last saw h 9T alive on 11-9 1946.

Immediate cause of death: Pulmonary Stas, Tuberculosis — Duration 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 11-11-46

VS 150

G45459 BCH D49217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190a

Registered No. G45459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 162 Colvin St. (location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estephanie JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1/46

8. AGE: Years	Months	Days	If less than one day
	5		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Baby.
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Johnson
(b) Address 162 Colvin Street

17 (a) Burial (b) Date thereof 11/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director G. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) [illegible] (b) Huntington Williams, M.D.

NOV 12 1946

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1946, at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Diarrhea and enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/9/46

G45160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G45160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 Myrtle Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SIDNEY FREEMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-2712

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Sneed Florida (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER	12. Name Peter Freeman
	13. Birthplace Florida
MOTHER	14. Maiden Name Sarah Hilliams
	15. Birthplace Florida

16 (a) Informant Willie mae Dixon
(b) Address 719- N. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) NOV 12 1946 (Date rec'd by Registrar) (b) Huntingdon Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/46 19 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 11/10/46

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G45161 BC. J-61952 BALTIMORE CITY HEALTH DEPARTMENT G45161

CERTIFICATE OF DEATH 1604

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738 George St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 738 George St.
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Elazer Byrd Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/7/46

8. AGE: Years	Months	Days	If less than one day
—	—	—	13 hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Elazer Byrd
13. Birthplace Winnsboro, S.C.

MOTHER
14. Maiden Name Thelma Bevans
15. Birthplace Baltimore, Md.

16 (a) Informant Thelma Byrd
(b) Address 738 George St

17 (a) Burial (b) Date thereof Nov 13 1946
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director G. Waldstad
(b) Address 918 Druid Hill Ave.

NOV 12 1946 Clayton Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946, at 2:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/46 19 , to 11/8 1946, and that I last saw him alive on 11/7 1946.

Immediate cause of death	Duration
Cardiac Respiratory Failure	
Due to Intracranial Hemorrhage	
Due to Hemorrhagic disease of the New born	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Clarence W Martin M. D.
Address 1111 Mondawmin Ave Date signed Nov 12 1946

G45162 fl. g. 61806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G45162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street.
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 E. Joppa Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy (B) Stang.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 10, 1946

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md. (Town/county, and state)
10. Usual Occupation —
11. Industry or business —

MOTHER / FATHER
12. Name Theodore Marvin Stang
13. Birthplace Baltimore Md.
14. Maiden Name Irma Kathryn Eichel
15. Birthplace Baltimore, Md

16 (a) Informant Mother
(b) Address 9 Irma Stang.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway
18 (a) Funeral director Elizabeth Hark Funeral Home
(b) Address 115 E. Mt. St.
19 (a) Date rec'd by registrar NOV 12 1946 Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Nov 1946 to 11 Nov 1946 and that I last saw h.im alive on 11 Nov. 1946

Immediate cause of death
Atelectasis — Duration
Due to Bronchial plug C
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cohen M. D.
Address South Balto Gen'l Hosp Date signed 12 Nov 46

X

G45163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Gorsuch Ave
(c) Hospital or institution: St. Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) Dft

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Gorsuch Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK LUCAS

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Katherine Lucas
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) May 1-1870

8. AGE: Years	Months	Days	If less than one day
76	6	9	____hr. ____min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Retired

FATHER
12. Name Anton Lucas
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Kreut
15. Birthplace Germany

16 (a) Informant Mrs Alberta Davis
(b) Address 1627 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem Co
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Arlington Ave Huntingtown Baltimore, Md

19 (a) NOV 12 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/46 19 ..., at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11/10/46

VS 151

G45164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G45164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2025 E Monument St~~
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 E Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Kloess.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widowed

6 (b) Name of husband or wife Henry Kloess
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 29 1865

8. AGE: Years	Months	Days	If less than one day
81	6	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name — Schmuck
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs John Dittmer
(b) Address 1713 E 33 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Uhlrich Funeral Home
(b) Address 2008 Orleans St

19 (a) Date received ~~Nov 12 1946~~ Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1946, at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to Nov 9 1946, and that I last saw h[illegible] alive on Nov 9 1946.

Immediate cause of death	Duration
Circulatory Collapse	3 days
Due to Hypertension Heart Disease Chronic Arthritis	3 yrs.
Due to Arteriosclerosis	
Other Conditions Cataracts both eyes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C H Meyer Dr M. D.
Address 1501 E 33rd St Date signed 11/10/46

VS 150

X

G45465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c

Registered No. G45165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 E. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 H
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 E. Baltimore St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William W. Blackburn

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Effie M. Blackburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1866

8. AGE: Years	Months	Days	If less than one day
79	11	2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Thomas Blackburn
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Woods
15. Birthplace Md.

16 (a) Informant Mrs. Milton H. Ballentine
(b) Address 3510 E. Baltimore St.,

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-14-46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) NOV 12 1946 **(b)** Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1946 at 3.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Nov 11 1946 and that I last saw him alive on Nov 10 1946.

Immediate cause of death	Duration
Paralysis Agitans	3 yrs.
Senile changes	10 +
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo A Lefferty M. D.
Address 5 Patterson Park Ave Date signed 11/12/46

VS 150

X

G45466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 130a

Registered No. G45466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 N. Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 N Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA PRICE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Rev. Wm a Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15 1865

8. AGE: Years	Months	Days	If less than one day
81	0	26	15 hr. 27 min.

9. Birthplace New York N.Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business 0

FATHER
12. Name Mathew Dodek
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace ?

16 (a) Informant Mrs Alice C. Wheeler
(b) Address 2616 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)

(c) Cemetery or crematory Chestnut Grove Ch. Cem.
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 12 1946 (b) (Accepted by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1946, at 3:27 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1946 to Nov 11 1946 and that I last saw her alive on Nov 11 1946

Immediate cause of death	Duration
Cerebral vascular accident	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Wheeler, M. D.

Address U. M. Hosp Date signed 11-11-46

X

G45167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G45167
Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital DOA

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Boyd (William Francis Boyd)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 296-10-5283

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie M. Perry
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Dec. 20th. 1895

8. AGE: Years	Months	Days	If less than one day
50	10	20	######## min.

9. Birthplace Parkers Landing, Penn.
(Town, county, and state)
10. Usual Occupation Glass Blower
11. Industry or business

FATHER
12. Name Miles Seymore Boyd
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah R. Edigner
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Carrie M. Boyd
(b) Address 1709 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Parkers Presbyterian
Location Parkers Landing. Pennsylvania

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

NOV 12 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 19t

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1946, at 1:43 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Iaconi M.D.
Medical Examiner.
Date signed 11/12/46

X

G45168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G45168 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3922 Dolfield Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3922 Dolfield Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Turner

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-03-2821

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary G. Meredith
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) March 23, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	17	##### min.

9. Birthplace Atlanta, Georgia (Town, county, and state)
10. Usual Occupation Stereotyper
11. Industry or business Balto: Sun Paper

FATHER
12. Name Chalmers Turner
13. Birthplace Georgia

MOTHER
14. Maiden Name Cassie Flynn
15. Birthplace Atlanta, Georgia

16 (a) Informant Mrs. Mary G. Turner
(b) Address 3922 Dolfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/46 (month) (day) (year)
(c) Cemetery or crematory Balto: National
Location Frederick road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

NOV 12 1946 (Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/46 19 , at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 19 46 to 11/10 19 46 and that I last saw h[illegible] alive on 11/10 19 46.

Immediate cause of death: Cerebral Hemorrhage — Duration 9 mins

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Hoffman M. D.
M. D.
Address 8 East Redd St Date signed 11/12/46

VS 150

X

G45169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45169 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3443 Dudley Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3443 Dudley Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Marie A. Clifford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert E.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29 1896

8. AGE: Years 50 | Months 9 10 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Hook
13. Birthplace Balto.

MOTHER
14. Maiden Name Marie L. Henson
15. Birthplace Balto.

16 (a) Informant Robert E. Clifford
(b) Address 3443 Dudley Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem. Co.
Location Old Frederick Rd.

18 (a) Funeral director John A. Hoffman
(b) Address 3700 E. Baltimore St

NOV 12 1946 (b) Huntingtor Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8, 1946 to Nov. 10 1946 and that I last saw her alive on Nov. 10, 1946.

Immediate cause of death	Duration
acute Coronary occlusion	
Due to Coronary Sclerosis	
Due to Malignant Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 300 Shannon Drive Date signed

× Nov 11-46

G45470 D.C. 9.61516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600

Registered No. G45470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Regester (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Bart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/46

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Bart
13. Birthplace Neb.

MOTHER
14. Maiden Name Veronica Rice
15. Birthplace Balto Md.

16 (a) Informant Mrs. Cecelia Rice
(b) Address [illegible] Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Jno. S. Falkowski
(b) Address 2007 Eastern Ave.

19 (a) 11-9-1946 (Signature of Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946 at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1946 to Nov 11 1946, and that I last saw him alive on Nov 11 1946.

Immediate cause of death Respiratory failure — Duration

Due to Subarachnoid hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Dorman M.D.
Address Johns Hopkins Hosp. Date signed 11/11/46

VS 150

G45171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G45171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town Newburg.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer D Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ruth Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 4 1892

8. AGE: Years	Months	Days	If less than one day
54	7	6	hr. min.

9. Birthplace Charles Co Md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER 12. Name James D Bailey
13. Birthplace Charles Co Md

MOTHER 14. Maiden Name Eva A Jackson
15. Birthplace Charles Co Md

16 (a) Informant Mrs Ruth Bailey
(b) Address Newburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-46 (month) (day) (year)
(c) Cemetery or crematory Holy Ghost Cem
Location Pope Md

18 (a) Funeral director Hunt & Ryon
(b) Address Waldorf Md

19 (a) (Date rec'd by registrar) (b) Williamson Mgr

VS 1 NOV 12 1946 Huntington Williamson Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1946, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1946, to 11-10 1946, and that I last saw him alive on 11-10 1946.

Immediate cause of death Respiration ceased — Duration

Due to Bronchogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Inoperable Caseous clump

of autopsy: Bronchogenic Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter L. Couch M. D.
Address University Hosp Date signed 11-10-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

P.C.B. 61510

G45472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G45472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette - John St.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 O'Donnell st.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Nebel

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	single

6 (b) Name of husband or wife New born
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1946

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation New born.
11. Industry or business

FATHER
12. Name John Conrad Nebel
13. Birthplace Tyrtenrach, Pa.

MOTHER
14. Maiden Name Regina Francis Polanowska
15. Birthplace Baltimore, Maryland

16 (a) Informant John Conrad Nebel
(b) Address 3039 O'Donnell St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) 11 (day) 13 (year) 46
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road + Dundalk

18 (a) Funeral director Jos. DUDA
(b) Address 2829 HUDSON St.

19 (a) (b)

NOV 12 1946

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946, at 5 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1946, to Nov 11 1946, and that I last saw h.s.r. alive on Nov 11 1946.

Immediate cause of death Respiratory failure — Duration

Due to Brain injury at birth 2° to difficult birth ???

Due to Face presentation

Other Conditions
Baby delivered by Caesarean section
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy Atelectasis Bilateral

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Dykema M. D.
Address Women's Hosp. Date signed 11-12-46

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45173 46F

Registered No. G45173

G45173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison Street
(c) Hospital or institution Lesawford Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 83 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 W. North Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE H. KRATZ

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jacob Kratz
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 19 June, 1863

8. AGE: Years	Months	Days	If less than one day
83	4	21	hr. min.

9. Birthplace: Baltimore City (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Henry Ficke
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Hilge
15. Birthplace: Baltimore

16 (a) Informant: Carl R. Kratz
(b) Address: 1807 Poplar Grove Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Road

18 (a) Funeral director: Walter Brooks Bradley
(b) Address: 1922 W. North Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 12 1946

MEDICAL CERTIFICATION P

20. DATE OF DEATH 10 November 1946, at 6:59 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946 to Nov. 10 1946 and that I last saw h[e]r alive on Nov. 10 1946.

Immediate cause of death	Duration
Carcinoma of Liver	??
Generalized Arteriosclerosis	?
Due to Hypertension Cardio-Vascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip F. Lerner
Address 2701 W. North Ave Date signed 11/11/46

X

G45174 BCH

JL - 106402 #159927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G45174

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 S. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Stouffer - [illegible] or Baby Boy Stauffer - [illegible]

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1946

8. AGE: Years	Months	Days	If less than one day
		22	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gordon Stouffer
13. Birthplace Md.

MOTHER
14. Maiden Name Betty Everett
15. Birthplace (or) West Virginia

16 (a) Informant Gordon D. Stouffer (Father)
(b) Address 236 S. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 46 (month) (day) (year)
(c) Cemetery or crematory Boonesboro Cemetery
Location Boonesboro Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St. Hagerstown, Md.

19 (a) (Signature of registrar) (b) Hagerstown, Md. Registrar

NOV 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946 at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1946, to Nov. 11 1946, and that I last saw h[illegible] alive on Nov. 11 1946.

	Duration
Immediate cause of death: Pneumonia	2 days
Due to	
Due to Prematurity	3 wks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) Was at work?
(e) Means of injury

23. Signature Julian F. Griffin M.D.
Address Bay City Hospital Date signed 11/11/46

G45475 | BALTIMORE CITY HEALTH DEPARTMENT | G45475 Registered No.

CERTIFICATE OF DEATH 48 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2338 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2338 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Giardina

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nicholas R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1887

8. AGE: Years 59 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Barnard
13. Birthplace Md.

MOTHER
14. Maiden Name Mary V. Sterrey
15. Birthplace Md.

16 (a) Informant Vincent Giardina
(b) Address 215 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. A. E. Sysgood & Sons
(b) Address Lombard & Penn Sts.

19 (a) (Date rec'd by registrar) (b)
NOV 12 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1946 at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1946, to Nov. 10 1946, and that I last saw him alive on Nov. 4 1946.

	Duration
Immediate cause of death: Ulceration of bowel	
Due to: Carcinoma	7
Due to: Uremia and Asthenia	2
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature H. J. Marx M. D.
Address 716 Cathedral Date signed Nov 11 46

G45476 ✓ G45476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dth
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town, write RURAL and give town)
(d) Street No. 1211 Glyndon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry E Schafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of ~~husband~~ or wife ~~late~~ alice M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1880

8. AGE: Years 66 | Months 0 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name ? Schafer
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs Thelma Wilhelm
(b) Address 1211 Glyndon Ave

17 (a) Burial (b) Date thereof Nov. 14, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location 2330 Frederick Rd.

18 (a) Funeral director Harry F Nitzke
(b) Address 4101 Edmondson Ave

19 (a) NOV 12 1946
(Date received by registrar)
Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1946, at 8:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelbrick M.D.
Medical Examiner.
Date signed Nov 14, 1946

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G45177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 145 N Caton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriet Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Leroy Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1925

8. AGE: Years	Months	Days	If less than one day
20	10	14 15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William Regary
13. Birthplace Md.

MOTHER 14. Maiden Name Harriet Fallon
15. Birthplace Md.

16 (a) Informant James LeRoy Davis
(b) Address 3 S. Caton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H Wetzler
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS NOV 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1946 at 1108 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1946 to 11/10 1946 and that I last saw h e r alive on 11/10 1946

Immediate cause of death Cardiac Failure.

	Duration
Due to 1- Chronic Glomerular Nephritis	
Due to 2- Hypertension	
3- Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: 1- Cardiac Enlargement 2- Chronic Glomerulonephritis 3- Arteriosclerosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilmour Gorsuch Jr M.D.
Address St. Agnes Hosp. Date signed 11/10/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

G45478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G45478 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cuyler & Ashland
(c) Hospital or institution West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Du Bois Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Greitgress

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1873

8. AGE: Years	Months	Days	If less than one day
73.	5	18	hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name John C. Finck
13. Birthplace Md.

MOTHER 14. Maiden Name Dora A. Metz
15. Birthplace Md.

16 (a) Informant Mrs. Lillian Gouris
(b) Address 3002 Du Bois Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 305 Harford Rd.

NOV 12 1946
(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 19 46 at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 9 19 46 to Nov 11 19 46 and that I last saw h e alive on Nov 11 19 46.

Immediate cause of death: Toxemia — Duration:
Due to Retroperitoneal abscess left.
Due to Surgical Necrosis of the fractured head + neck of left femur.
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 5, 1946 at M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? (Specify trade or place) no
(e) Means of injury Burned in fall in home

23. Signature Lester G. Hall M. D.
Address Res + Balto Gen Hosp Date signed 11/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

VS 150

Huntington Williams, M.D.

Howard J. Crandin, M.D. 105

G45179 ✓G45179

TH. 105555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 St Ambrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Reginald Ganley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19th 1897

8. AGE: Years 49 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Micheal Ganley
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Gunn
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave. (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-46 (month) (day) (year)
(c) Cemetery or crematory Mem. Meth.
Location Old Frederick Rd

18 (a) Funeral director John. J. McGann
(b) Address 3000 E. Baltimore St.
(c) (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10th 1946 at 11:50 AM ~~10:50~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25th 1946 to Nov. 10 1946 and that I last saw h im alive on Nov. 10th 1946

Immediate cause of death
Pulmonary Atelectasis,
Far Advanced
Due to
Due to
Other Conditions Terminal of Life,
Pneumonia Call of Life,
(Include pregnancy within 3 months of death)

Duration
6 hrs

Date of operation
Major findings of operations
Same as above
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 11-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G45180 BG# B57010 BALTIMORE CITY HEALTH DEPARTMENT ✓ G45180
CERTIFICATE OF DEATH 157E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSP. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) 2 MOS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. JEFFERSON APTS, CITY 18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TIMOTHY JAY MOHAN
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex MALE
5. Color or race WHITE
6 (a) Single, ~~married, widowed, or divorced~~
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 20 Sept 1946
8. AGE: Years | Months 1 2 | Days 21 | If less than one day hr. min.
9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation INFANT
11. Industry or business

FATHER
12. Name JOSEPH F. MOHAN
13. Birthplace ILLINOIS

MOTHER
14. Maiden Name LAURA REED
15. Birthplace ILLINOIS

16 (a) Informant JOSEPH F. MOHAN
(b) Address JEFF. APTS, CITY, 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Edmondson Ave.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St Paul St

19 (a) NOV 12 1946 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1946, to Nov 11 1946, and that I last saw h~~is~~er alive on Nov 11 1946

Immediate cause of death
Cardiac failure — Duration 24 hrs.
Due to Congenital Heart disease — Duration Years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Aortic stenosis, congenital
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold D. Cooper M.D. M. D.
Address Union Memorial Hospital
Date signed Nov 11 1946

Huntington Williams, MD

VS 150

G45481

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

G45481
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Edgewood- Box 191 (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph L. Starr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1931

8. AGE: Years	Months	Days	If less than one day
15	2	17	hr. min.

9. Birthplace Edgewood, Harford Co., Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Eason Starr
13. Birthplace Virginia

MOTHER
14. Maiden Name Ozie Sutphin
15. Birthplace Virginia

16 (a) Informant Mrs. Ozie E. Starr
(b) Address Edgewood Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Fountain Green, Md.

18 (a) Funeral director Howard K. McComas & Son
(b) Address Abingdon Md.

(a) (Registrar) (b)

NOV 12 1946

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1946 at 7.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-46 at about 4 P. M. Harford Co.
(b) Where did injury occur? Pulaski Highway near Joppa, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Fell off motor cycle.

23. Signature Thomas J. Maldeis M.D.
Medical Examiner.
Date signed 11-11-46

G15182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G15182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 W North Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Feintuch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Meyer Friedman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Mrs Toba Fried
(b) Address 819 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 13, 19[illegible] (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV. 13 1946 (Date rec'd by registrar) (b) Huntington White[illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1946, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30/46 1946 to 10/12 1946, and that I last saw h[illegible] alive on 10/12/ 1946.

Immediate cause of death — Duration
Bronchopneumonia — 2 days
Generalized Arteriosclerosis — ?
Due to Arteriosclerotic Cardio-Vascular Disease — ?
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F Leiser M. D.
Address 2701 W. North Ave. Date signed 10/13/46

X

G35183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G35183

Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph H. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Susan E. Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1881

8. AGE: Years	Months	Days	If less than one day
65	4	13	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Casting Rolling Mill

FATHER
12. Name Richard Dorsey
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs. Susan E. Dorsey
(b) Address 1322 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-46 (month) (day) (year)
(c) Cemetery or crematory Mem Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

NOV 13 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10-1946, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6-1946 to 11-10-1946 and that I last saw h alive on 11-9-1946.

Immediate cause of death Cardiovascular renal disease — Duration One yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. S. Campbell M. D.
Address 639 N. Carey St Date signed 11-12-46

VS 180

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G45184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Brendan Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Brendan Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Theodore Kesting

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie Simmons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1891

8. AGE: Years 74 | Months 11 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Cabinet Maker
11. Industry or business Manufacturing

FATHER
12. Name Louis Kesting
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretha Gneiter
15. Birthplace Germany

16 (a) Informant Elmer F Kesting
(b) Address 3119 Elbank Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 15 46 (month) (day) (year)
(c) Cemetery or crematory Taylwood
Location Parkville Md

18 (a) Funeral director Wilson Conkling
(b) Address 1219 H Cont St

19 (a) (Date rec'd by registrar) (b) (Registrar)

NOV 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1946, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1946, to 11/11 1946 and that I last saw h[illegible] alive on 11/11 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 7 days
Due to: Arteriosclerotic
Due to: Cardio-Vascular Disease
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work)
(e) Means of injury

23. Signature H G Stevens M.D.
Address 3403 Eutaw Pl Date signed 11/12/46

Huntington Hillsides, Md

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45185 1310a

Registered No. G45185

G45185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Hanover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E Gontrum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrie A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22. 1869

8. AGE: Years	Months	Days	If less than one day
77	9	20	hr. min.

9. Birthplace York Pa (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Conrad Gontrum
13. Birthplace Unknown

MOTHER 14. Maiden Name Louisiana Cramer
15. Birthplace Unknown

16 (a) Informant Carrie A Gontrum
(b) Address 1709 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Ridge
Location Longview Md Pa

18 (a) Funeral director Wilson Colt Co
(b) Address 1217 E Pratt St

19 (a) NOV 13 1946 (Date received by registrar) (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1946 at 10 12 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Nov. 12 1946 and that I last saw h alive on Nov 10 1946

Immediate cause of death Uremia — Duration 3 days

Due to Chronic Nephritis — —

Due to Generalized Arteriosclerosis — —

Other Conditions Senile Psychosis — —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Kohn M. D.
Address 1026 Fort ave Date signed 11/14/46

G45186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G45186 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NJ (b) County
(c) City or town Camden (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Pearl St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Mc Closkey, Edwin Franklin

3 (b) If veteran, name war —

3 (c) Social Security Account No. --

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Jansko Mc Closkey

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 28, 1893

8. AGE: Years 53 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Phila, Pa. (Town, county, and state)

10. Usual Occupation Deckhand

11. Industry or business Seafarer

FATHER
12. Name John Mc Closkey
13. Birthplace Princeton, NJ

MOTHER
14. Maiden Name Lena Stien
15. Birthplace Philadelphia, Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory Camden
Location Camden

18 (a) Funeral director Sullivan & Dare
(b) Address 1217 Ft Comb Pl

19 (a) (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1946, at 9:10AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1946 to Nov. 12 1946, and that I last saw him alive on Nov. 12 1946

	Duration
Immediate cause of death Hypertensive cardiovascular disease	4 yrs.
Due to Other conditions: Cardiac insufficiency, bundle branch block	3 yrs.
Other Conditions Pulmonary edema	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G35187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6619 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Kalis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Benjamin Kalis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER	12. Name Samuel
	13. Birthplace Russia
MOTHER	14. Maiden Name Dora
	15. Birthplace Russia

16 (a) Informant Benjamin Kalis
(b) Address 6619 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewin Inc
(b) Address 429 E Balto St
(c) Date received NOV 13 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1946, at 1:25 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 11 1946, to Nov. 12 1946, and that I last saw her alive on Nov. 12 1946.

Immediate cause of death	Duration
Resp failure	2
Due to Papillary cystadeno-carcinoma of ovary	11 Mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan 1946
Major findings of operation: Tumor mass
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Royce Lee Brown M. D.
Address Sinai Hosp Date signed 11/14/46

VS 150

Spec.—8-29-25—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G45188 — CERTIFICATE OF DEATH 12-1 1946 — G45188

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3814 Greenmount ST., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah E. Paterson

(a) RESIDENCE NO. 3814 Greenmount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert R. Paterson — Widow

6 DATE OF BIRTH (month, day, and year): Feb. 24, 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: -

(b) General nature of industry, business, or establishment in which employed (or employer): -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: -Amos Ripple

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: -- Showers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mrs. James Fairbanks, Jr.
(Address): 3712 Greenmount Ave.

15 Filed NOV 13 1946, 19 Huntington Williams Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 1946

17 I HEREBY CERTIFY, That I attended deceased from 1945, 19 , to Nov 12, 19 46, that I last saw her alive on Nov 11, 19 46, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-vascular disease

(duration) 5+ yrs. mos. da.

CONTRIBUTORY (Secondary): Myocarditis (duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. V. D. Mack, M. D.

, 19 (Address) 513 E 39th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London PK	11-14-46
20 UNDERTAKER	ADDRESS
Wm J. Tickner & Sons	North & Penna

6. DEATH in [illegible] in terms so that it may be properly classified. Exact statement of [illegible] important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G45189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Tudor Arms Apts. University Pkwy. & Tudor Arms Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. University Pkwy. & Tudor Arms Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA C. BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank G. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	18	hr. min.

9. Birthplace Columbus, Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Dickinson
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Frank G. Brown
(b) Address Tudor Arms Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1946 at 11.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 11 1946 and that I last saw h alive on Nov 11 1946

Immediate cause of death
Chron Myocarditis
Chron Interstitial Nephritis — Duration 1940 / 1940

Due to

Due to

Other Conditions Acute Cardiac Dilatation — 1946

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Bishop M. D.
Address 503 Sheridan Av Date signed Nov 12 46

VS 150

NOV 13 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 51B

Registered No. G45190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3608 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RICHARD H. DOUGHERTY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Arinthia A. Dougherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1859

8. AGE: Years	Months	Days	If less than one day
87	1	24	hr. min.

9. Birthplace Crisfield, Md. (Town, county, and state)
10. Usual Occupation Ship Smith
11. Industry or business Self - retired 7 yrs.

FATHER
12. Name Wm. Hy. Dougherty
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name Mary Bradshaw
15. Birthplace Hopewell, Md.

16 (a) Informant Mrs. E. Ruth Price
(b) Address 3608 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Wills Registrar

NOV 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1946, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1946 to Nov. 11, 1946 and that I last saw him alive on Nov. 11, 1946

Immediate cause of death	Duration
Carcinoma of Prostate Metastis Liver	1 yrs
Due to Toximenia	2 Dy.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Aug. 1936
Major findings of operation:
Carcinoma of Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 2757 W. Fremont Date signed 11/13/46

X

G45191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45191 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2353 Druid Hill
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2353 Druid Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT ELLIOTT

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-2164

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	M	Married

6 (b) Name of husband or wife Carrie E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18, 1881

8. AGE: Years	Months	Days	If less than one day
65	2	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Horse Painter

11. Industry or business

FATHER
12. Name Elliott
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Carrie E Elliott
(b) Address 2353 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory Windsor
Location Windsor Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 E Fayette St

19 (c) NOV 13 1946 Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/46 19 , at 10:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P Davis, M.D.
Medical Examiner.
Date signed 11/11/46

OVER.

G45192 BALTIMORE CITY HEALTH DEPARTMENT G45192
CERTIFICATE OF DEATH 163H Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 N Bentalow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Levi

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Bertha M. Levi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 15, 1888.

8. AGE: Years 58 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Lynchburg, Va. (Town, county, and state)
10. Usual Occupation Insurance Salesman.
11. Industry or business

FATHER
12. Name Sigmund Levi,
13. Birthplace Germany.

MOTHER
14. Maiden Name Carrie Moses,
15. Birthplace Lynchburg, Va.

16 (a) Informant Mr. William A. Levi (Son)
(b) Address 1722 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnenschein's Sons
(b) Address 1902 Eutaw Place.

19 (a) (b) Huntington, Md.

NOV 19 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1946 at 7 30 M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to Illuminating Gas
Due to
Other Conditions Carcinoma of colon
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov 12 at 7 00 A M.
(b) Where did injury occur? 1722 N. Bentalow St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Means of injury Inhaled gas from open burner

23. Signature William J. Holbrook M.D.
Medical Examiner.
Date signed Nov 17'46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G45193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Pentridge Apartments
(b) Street address Loch Raven Rd + Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Loch Raven Blvd + Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Rosendorn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1861

8. AGE: Years 85 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franz Rosendorn
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Schultz
15. Birthplace Germany

16 (a) Informant Wilhelmina Rosendorn
(b) Address Loch Raven Blvd + Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1946, at 2:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1946 to Nov 12 1946 and that I last saw h.. alive on Nov 11 1946

Immediate cause of death: Cerebral Hemorrhage (apoplexy) — Duration Nov 4/46

Due to:

Due to:

Other Conditions: Arterio Sclerosis a number of years. — a number of years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Green M.D.
Address 3009 Evergreen Ave Date signed 11/13/46
Baltimore 14 Maryland

VS 1946 NOV 13 1946 Registrar Williamsport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G45194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Gatonaves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Lyndenhurst St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Miss Edna Mae Keyser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-1893

8. AGE: Years 53 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation House.

11. Industry or business Charles Nor. William

FATHER
12. Name Edna Mae Keyser
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Edna Mae Keyser
15. Birthplace Baltimore, Md.

16 (a) Informant Dan Hahn.
(b) Address 324 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Leimbach
(b) Address 525 Lynhurst St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1946, at 10.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1946, to 11-12 1946, and that I last saw h[illegible] alive on 11-12 1946.

Immediate cause of death Cardiac failure, Cerebral edema
Due to Ca's Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury D.W. MINTZER

23. Signature D.W. Mintzer M.D.
Address St. Agnes Date signed 11/14/46
Howard L. Clemmens, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G45195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G45195 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp
(c) Hospital or institution: Division st
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Md.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2441 McCulloh St. (If rural give location)
(e) Citizen of foreign country? no, (Yes or No)
If yes, name country

3 (a) FULL NAME John Contee

3 (b) If veteran, name war: W. W. I
3 (c) Social Security Account No. ??
4. Sex: M
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife: Edna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 25 1894
8. AGE: Years 52 | Months 2 | Days 17 | If less than one day: hr. min.
9. Birthplace Aquasco Md (Town, county, and state)
10. Usual Occupation Railroad
11. Industry or business

FATHER
12. Name William Contee
13. Birthplace Aquasco Md

MOTHER
14. Maiden Name Matilda Cheseley
15. Birthplace Aquasco Md

16 (a) Informant Edna Contee
(b) Address 2441 McCulloh St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 15 (day) 46 (year)
(c) Cemetery or crematory Interstate
Location Md.
18 (a) Funeral director Geo. H. Kelsan
(b) Address 1303 Pressman St
19 (a) (Date rec'd by registrar) NOV 13 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/1946 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1946 to 11-11 1946 and that I last saw h. alive on 11/11/46 at 12 M.

Immediate cause of death Embolism
Pulmonary.
Due to
Due to
Other Conditions Pneumonia.
Hernioplasty.
(Include pregnancy within 3 months of death)
Date of operation 11/7/46.
Major findings of operation: Rt Inguinal Hernioplasty
of autopsy: None.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Brodnax Hagner M. D.
Address 843 Cradock Date signed 11-13-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45496 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 School St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 School St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannie Fincher

3 (b) If veteran, name war: None
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Chas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1873

8. AGE: Years 72 | Months 11 | Days | If less than one day: hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace

MOTHER
14. Maiden Name unobtainable
15. Birthplace

16 (a) Informant Mack Fincher
(b) Address 1418 School St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelly
(b) Address 1303 Presbury St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/1946 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/1946 to 11/11/1946 and that I last saw him alive on 11/9/1946

Immediate cause of death	Duration
Chronic Myocarditis	3yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
M. Signature H. W. Williams, M.D.
Address 45 W. Biddle St Date signed 11/13/46

X

G45497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G45497 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 662- Haw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1870

8. AGE: Years 76 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name George Brown
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Martha Lynn
15. Birthplace Howard Co. Md.

16 (a) Informant Martha Diggs
(b) Address 925 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R Billings
(b) Address 322 N Schroeder St

19 (a) NOV 13 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1946, at 1.15 A M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
*1 Pulmonic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11/12/46

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G45198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Pennington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Isaac Pennington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1879

8. AGE: Years 67 Months 4 Days If less than one day hr. min.

9. Birthplace Chase City Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Melvin Pennington

(b) Address 1406 Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mr Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1946 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1946 to 11/10 1946, and that I last saw h alive on 11/10 1946.

Immediate cause of death: Congestive Heart Failure

Due to: Arteriosclerotic Heart Disease

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 week

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. W. Hamilton M.D.

Address 4 E. Mulberry Date signed 11/11/46

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45199
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 3mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Lucas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Archie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 17- 1899

8. AGE: Years	Months	Days	If less than one day
47	(3) 1	23	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Hunt
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov. 14, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Belnord Ave Huntington Woodside, Md

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10- 1946, at 3.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1946, to 11-10 1946 and that I last saw h alive on 11-10 1946.

Immediate cause of death	Duration
Peripheral Circulatory Failure	1 day
Due to Diabetes Mellitus	years
Due to	
Other Conditions Carcinoma, Uterus, Abscess of abd wall.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund A. Beacham M. D.
Address Baltimore, Md. Date signed 11 Nov 46

VS 150

G45500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1246

Reg. G45500

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-14 Division
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Garrison William Gallop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Maggie Gallop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1909

8. AGE: Years 36 Months 11 Days 13 If less than one day hr. min.

9. Birthplace Mamie North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George J. Gallop

13. Birthplace

MOTHER 14. Maiden Name Amandilla Garrison

15. Birthplace

16 (a) Informant George Gallop

(b) Address 1005 Edmondson Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov 13, 1946 (month) (day) (year)

(c) Cemetery or crematory Mamie N.C.

Location

18 (a) Funeral director Mr. Kater R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Certificate No. Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1946, at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1946 to Nov 9 1946, and that I last saw him alive on Nov 9th 1946.

Immediate cause of death Cardiac Failure — Duration

Due to Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 8 E. Madison St. Date signed Nov 13 1946

G45501 51396 Birth Certificate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G45501 Registered No.

1. PLACE OF DEATH: B-66700
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 35-10 East Ave. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Zeller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife 11-11-46
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-46

8. AGE: Years | Months | Days: 1 | If less than one day: 24 hr. 5 min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Raymond Zeller
13. Birthplace Md.

MOTHER
14. Maiden Name Jean Wilson
15. Birthplace England Florida

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd. Balto Co.
18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.
19 (a) NOV 13 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1946 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1946 to Nov. 12 1946 and that I last saw her alive on Nov. 11, 1946

Immediate cause of death: PREMATURITY — Duration: LIFE
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp. Date signed 11/12/46

VS 150

X

correct age as accurately as possible; physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1117a

G45502 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 Light St
(c) Hospital or institution: South Baltimore Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 Null St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Klemmick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Klemmick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/89

8. AGE: Years 57 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business unemployed

FATHER 12. Name John Klemmick
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Sauers
15. Birthplace Maryland

16 (a) Informant Mrs. M. Klemmick
(b) Address 1239 Null St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-46 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Frederick Ave.

18 (a) Funeral director Hoss & Hill
(b) Address 1501 E Fort Ave.

19 (a) NOV 13 1946 (Date received by Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1946, to Nov 11 1946, and that I last saw him alive on Nov 11 1946.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic and Hypertensive Heart Disease	
Due to	
Other Conditions Peptic Ulcer	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Carrington M.D.
Address 10 Balto St Hos Date signed 11/14/46

937

Dr. Barranco
436 Fort Ave.
5. G45503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G45503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 N. Eutaw Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 N. Eutaw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Le Roy West

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1893 ?

8. AGE: Years	Months	Days	If less than one day
53?	8	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Supt. A? & P.
11. Industry or business

FATHER
12. Name Columbus West
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Korber
15. Birthplace ?

16 (a) Informant Mr. Russell West
(b) Address 3223 Orlando Avenue -14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) (b)
(Date received by registrar) Registrar

NOV 13 1946
VS 150

Huntington Williams, M.D.
for C. J. Lubinski

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to Nov 11 1946 and that I last saw him alive on Nov 8 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Obesity	
Due to Phlebitis of right Leg	1 month
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. L. J. Barranco
Address 436 Fort Ave Date signed 11/14/46
M. D.
Howard J. Mengers, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-98782 G45504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G45504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 23days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4610 White Avenue
(If rural give location)
(e) Citizen of fordign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Chambers (William Charles Chambers)

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	220-05-7787

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Ethel Hughes Chamb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18- 1871

8. AGE: Years	Months	Days	If less than one day
75	7	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Compositor - Retired
11. Industry or business Balto. News - Post

FATHER
12. Name Richard Chambers
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Jane Newell
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 13 1946 (Date received by registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11- 1946 at 5.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18- 1945 to 11- 11- 1946; that I last saw h alive on 11-11- 1946

Immediate cause of death — Duration

Miliary T.B. — 2 mos.

Due to — ?

Due to — while

Other Conditions Hypertensive Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Miliary T.B.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Rahmann Jr. M. D.
Address Balt. City Hosp. Date signed 11/13/46

VS 150

G45505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45505
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA CECLIA MORELAND

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife. Alfred A. Moreland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1865

8. AGE: Years	Months	Days	If less than one day
81	0	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph W. Batty
13. Birthplace England

MOTHER
14. Maiden Name Cecilia Lynch
15. Birthplace England

16 (a) Informant Mr. Alonzo Moreland
(b) Address 1613 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/ 14/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946 at 2.15 A. M. P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1931 to Nov 10 1946 and that I last saw h alive on Nov 10 1946.

Immediate cause of death — Duration

Uremia — 4 days
Due to Arterio-Sclerotic Hypertensive Cardio Renal Disease — 14 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Spindler M. D.
Address 1701 E. Fayette St Date signed 11/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G45506

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4607 Walther Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Walther Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUST HENRY MAY

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mary Elizabeth May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1871

8. AGE: Years	Months	Days	If less than one day
75	2	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business Baltimore police dept

FATHER
12. Name August H. May
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace Germany

16 (a) Informant Mrs. Lillian R. Walter
(b) Address 4607 Walther Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) 11-13-1946 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION P. M

20. DATE OF DEATH Nov. 10 1946 at 7.55 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 1920 to Nov 10 1946, and that I last saw h[illegible] alive on Nov 10 1946.

Immediate cause of death: Cerebral hemorrhage
Duration 6 months
Due to: Stroke
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature [illegible]
Address 3325 Dalton Ave Date signed 11/14/46 M.D.

VS 180

G15507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G15507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Harford Road. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALVERTA E MERRIKEN (ALVERTA EUGENA MERRIKEN)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Ernest M Merriken
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 3/7/80

8. AGE: Years	Months	Days	If less than one day
66	7	4	hr. — min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Augustus W. Moore
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E Williams
15. Birthplace Maryland

16 (a) Informant Ernest M. Merriken
(b) Address 3008 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) — (by) — (Date rec'd by registrar) — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1946 to 11/11 1946 and that I last saw her alive on 11/11 1946

Immediate cause of death — Duration
Coronary Thrombosis — 1d
Due to Intracranial Hemorrhage — 2
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature [signature] M. D.
Address [illegible] Date signed 11/14/46

[illegible] for [illegible]

G45508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1572

G45508

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Niles
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Main St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Broadhove Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-29-33

8. AGE: Years	Months	Days	If less than one day
13	3	15	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Broadhove

13. Birthplace W. Va.

MOTHER 14. Maiden Name Gladys Winter

15. Birthplace W. Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/46 (month) (day) (year)

(c) Cemetery or crematory Niles Cem.

Location Niles Ohio

18 (a) Funeral director John O. Mitchell & Son

(b) Address 1900 Eutaw Place

19 (a) ~~Nov. 13 1946~~ Nov 13 1946 (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946, at 7 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1946, to Nov. 13 1946, and that I last saw him alive on Nov. 13 1946.

Immediate cause of death Cerebral Thrombosis — Duration 24 hrs

Due to Tetralogy of Fallot — Duration Life

Due to

Other Conditions Post operative atelectasis pulm. anasarca

(Include pregnancy within 3 months of death)

Date of operation 10/10/46

Major findings of operation: Tetralogy of Fallot

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry T. Bahnson

Address Johns Hopkins Hosp. Date signed 11/17/46 M. D.

VS 150

G45509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G45509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelle Goode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife James Goode
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Va. (Town, county, and state) N. York
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name James Addison
13. Birthplace

MOTHER 14. Maiden Name Annie Clarke
15. Birthplace

16 (a) Informant James Goode.
(b) Address 1714 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem.
Location Baltimore City

18 (a) Funeral director George L. A. Gibson
(b) Address 1736 Druid Hill Ave

NOV 13 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1946, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8, 1946, to Nov. 13 1946, and that I last saw h. alive on Nov 13, 1946.

Duration

Immediate cause of death Cardiac failure
Due to Coronary occlusion
Due to Coronary occlusion
Other Conditions Cerebral Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
Date of autopsy: Subject to Post Mortem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry C. Hill, M.D. M. D.
Address Union Memorial Hosp. Date signed 11/14/46

G45510 BALTIMORE CITY HEALTH DEPARTMENT G45510
CERTIFICATE OF DEATH 93D Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution: Church Home & Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 77yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 N Charles St. Apt 1A (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Enoch Pratt Hyde.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs Mary Adelaide Lovering Hyde
6 (c) If alive give age? years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1869.

8. AGE: Years	Months	Days	If less than one day
77	9	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Retired

FATHER
12. Name Arnold S Hyde
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Adelaide Baird
15. Birthplace Philadelphia

16 (a) Informant Mrs Mary Adelaide Hyde.
(b) Address 3502 N Charles St Apt 1A

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14 1946 (month) (day) (year)
(c) Cemetery or Crematory Green Mount
Location Baltimore

18 (a) Funeral director Henry H Tenkins Sons
(b) Address McCulloh Richard Sts.

19 (a) Nov 14 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1946, at 6 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1946, to Nov 12 1946, and that I last saw him alive on Nov 12 1946.

Immediate cause of death: Interstitial pneumonia (Duration: 4 days)
due to Embolism (Duration: 4 days)
Pulmonary embolism due to embolism cause
Due to Arteriosclerotic heart disease (Duration: 15 yrs)
Arteriosclerosis general (Duration: 15 yrs)
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None.
Major findings of operation: autopsy 1) infarct at lower lobe. 2) Embolism of
of autopsy: heart disease, 2) Arteriosclerosis general

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Bachrach
Address Church Home Hospital Date signed M. D. 11/12/46

X

G45511 (G45511)

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G45511

CERTIFICATE OF DEATH 46 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D C (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Bryant St N E. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Ball Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-16-88

8. AGE: Years	Months	Days	If less than one day
57 58	10	30 28	hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation N. B. J

11. Industry or business

FATHER
12. Name Robert Ball
13. Birthplace N.Y.

MOTHER
14. Maiden Name Emma Merrill
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11 13 1946 (month) (day) (year)

(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director A. Frank Reiss
(b) Address Washington, D. C.

19 (a) (Date rec'd by registrar) (b) Washington Williams Registrar

NOV 14 1946

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946 at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946 to Nov 13 1946 and that I last saw h alive on Nov. 13 1946.

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions Carcinoma Stomach (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address [signature] Date signed Nov 14 1946

G45512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45512

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2049 Kennedy Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Kent
(c) City or town Chestertown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Grace Fowler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife W. L. Fowler
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1874

8. AGE: Years	Months	Days	If less than one day
72	3	6	hr. min.

9. Birthplace Budapest Germ. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Unknown.
13. Birthplace "

MOTHER
14. Maiden Name Unknown.
15. Birthplace "

16 (a) Informant Mr. W. L. Fowler (Husband)
(b) Address Chestertown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)
(c) Cemetery or crematory Chester
Location Chestertown, Maryland.

18 (a) Funeral director Marvin V. W. Williams
(b) Address Chestertown, Maryland.

19 (a) (b) Huntington Williams
(Date received by registrar)

NOV 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946, at 9:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1941 to Nov 13 1946 and that I last saw HER alive on Nov 17 1946

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Arteriosclerotic Heart Disease	5 yrs.
Due to	
Other Conditions Pernicious Anemia (Include pregnancy within 3 months of death)	6 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawson
Address 4808 Harford Rd. Date signed M. 11 D. 13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G45513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 W. Lexington St.
(c) Hospital or institution: Aged Men & Aged Women's Home - 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Paine

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 21, 1873

8. AGE: Years 73 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Paine
13. Birthplace Unknown

MOTHER
14. Maiden Name Alcelia Carter
15. Birthplace Unknown

16 (a) Informant Supt Aged Womens Home
(b) Address 1404 W Lexington St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek
Location Carroll Co Md

18 (a) Funeral director Tilhorn & Sons
(b) Address 1217 E Cold St

NOV 14 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1938 to 11/13 1946, and that I last saw h er alive on 11/12/ 1946.

Immediate cause of death: Coronary occlusion — Duration: Sudden

Due to

Due to

Other Conditions: Arterio-sclerotic heart disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd B. Jarrell. M. D.
Address 11 E. Chase St., City 2 Date signed 11/13/46.

G15514 AB- 37504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G15514 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1- & 2 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angus Washington Staunton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married- Separated

6 (b) Name of husband or wife Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August- 5- 1882

8. AGE: Years	Months	Days	If less than one day
64	2	26	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER 12. Name David Staunton
13. Birthplace Virginia

MOTHER 14. Maiden Name Cary Staunton
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospital Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 12 1946
18 (a) Funeral director Commissioner of Health
(b) Address
NOV 14 1946 (Date rec'd by registrar) Acting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31- 1946 at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29- 1938 to 10-31 1946 and that I last saw h in alive on 10-31 1946

Immediate cause of death Pulmonary Tuberculosis — Duration 17 months

Due to

Due to

Other Conditions Syphilitic Cardio-Vascular Disease — Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. G. Bird
Address Balto City Hospa Date signed Nov 9 '46

VS 150

X

G15515

JL - 105380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15515 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Lena (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1884

8. AGE: Years	Months	Days	If less than one day
62	2	17	hr. min.

9. Birthplace Tenn.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sam Williams
13. Birthplace Ala

MOTHER
14. Maiden Name Ida Billie
15. Birthplace Miss

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 14 1946 Hunter Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1946 at 12:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1946 to Oct. 29 1946, and that I last saw him alive on Oct. 29 1946

Immediate cause of death: Respiratory Failure — Duration

Due to Carcinomatosis

Due to Syphilitic Cirrhosis

Other Conditions Hypertensive Cardio Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. R. Heathcock M.D.
Address Balto City Hosp. Date signed 11-9-46

VS 150

G15516

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-25024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G15516 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9yrs-3mo.-15days
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 West Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Dan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Chinese	Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5- 1882 or March 1- 1882

8. AGE: Years	Months	Days	If less than one day
64 or 64	7 or 7	24 or 29	hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Laundry

11. Industry or business

FATHER
12. Name ?
13. Birthplace California

MOTHER
14. Maiden Name ?
15. Birthplace California

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 12 1946
18 (a) Funeral director Commissioner of Health
(b) Address
19 NOV 14 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Oct. 30-1 1946, at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1937, to 10-30 1946, and that I last saw h im alive on 10-30 1946.

Immediate cause of death Bronchopneumonia, Bilateral — Duration Imm.

Due to

Due to

Other Conditions Paralysis Agitans
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr.
Address Balt. City Hosp. Date signed 11/6/46

VS 150

G15517 B.C.D. 9-61811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G15517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen'l Hosp 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Belvedere Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Palumbo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 Nov 46

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Palumbo
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rose M. Cubetta
15. Birthplace Baltimore Md

16 (a) Informant Rose Palumbo
(b) Address 3023 Belvedere Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 12 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

NOV 14 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1946 at 12^20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Nov 1946 to 6 Nov 1946 and that I last saw h[illegible] alive on 6 Nov 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity Weight 14 oz.	
Due to 20 weeks gest.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cohen
Address South Balto. Gen'l Hosp Date signed M. 11 D. 11/46

VS 150

G45518 B.C. 9-61985

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 159 ✓

Registered No. G45518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to give correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Elkridge -27- Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. 5616 Main St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Champion

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1946

8. AGE: Years	Months	Days	If less than one day
			11 hr. 35 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Vernon Ford Champion
13. Birthplace North Carolina

MOTHER
14. Maiden Name Jana May Harrell
15. Birthplace Baltimore, Md

16 (a) Informant Hospital Records
(b) Address Bon Secours Hosp., Balto, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1946, at 12 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1946, to Nov. 9 1946 and that I last saw her alive on Nov. 9 1946.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Prematurity (30 weeks)

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M.D.
Address Bon Secours Hosp. Date signed 11-9-46

VS 180

X

G45519 B.C. B-62211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G45519 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood St.
(c) Hospital or institution: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town.)
(d) Street No. 204 Hamlin Court (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hull

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/46

8. AGE: Years | Months | Days | If less than one day: 6 hr. 30 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name James A. Hull
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Helena Cornish
15. Birthplace Baltimore MD.

16 (a) Informant Mrs. Helen Hull
(b) Address 204 Hamlin Court

17 (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (month) (day) (year)
(c) Cemetery or crematory Location University Medical School

NOV 12 1946
Commissioner of Health

18 (a) Funeral director _____
(b) Address _____

NOV 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1946, at 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1946 to Nov. 7 1946, and that I last saw him alive on Nov. 7 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	
Due to Premature birth	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation _____
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Bridges, M.D.
Address Univ. Maryland Hospital Date signed 11/7/46

G25520 BC. J-61096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G25520 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene
(c) Hospital or institution:
Univ. Hosp — 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 259 N Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Merrick

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-2-46

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name Sadie Merrick
15. Birthplace

16 (a) Informant Sadie Merrick
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 14 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1946 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1946 to 11-9 1946 and that I last saw h, m alive on 11-9 1946.

Immediate cause of death Prematurity

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Bruce M. D.
Address Univ Hosp Date signed 11-10-46

VS 150

X

G15521 BC# G59442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G15521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name of county)
(d) Street No. 3229 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brailer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/12/46

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Lucy Brailer
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 14 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1946 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~10-25~~ 1946 to 11-6 1946, and that I last saw him alive on 11-6 1946

Immediate cause of death Toxemia
Infectious Diarrhea

Due to

Due to

Other Conditions Malnutrition
Dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan J. Driggs M.D.
Address Univ Hosp Date signed 11-6-46

VS 150

G15522 Paul Cochrane G-4448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157M

Registered No. G15522

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E. 21st St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lucas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-46

8. AGE: Years | Months | Days: 1? | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name George Lucas
13. Birthplace Md

MOTHER — 14. Maiden Name Nancy Kirby
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 12 1946

18 (a) Funeral director Commissioner of Health.
(b) Address

NOV 14 1946 (Date rec'd by registrar) (d) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1946 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1946 to Oct 31 1946 and that I last saw him alive on Oct 31 1946.

Immediate cause of death: Multiple Congenital Anomalies — Duration: Life

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Mauer M. D.
Address Johns Hopkins Hosp. Date signed 11/2/46

VS 150

DC 064689

G45523A 51134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G45523
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/46

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Lyla Thompson
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 12 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1946, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1946 to Nov 6 1946 and that I last saw him alive on Nov 6 1946

Immediate cause of death Respiratory failure

Due to Diarrhea

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Dorman
Address Johns Hopkins Hosp. Date signed 11/7/46

VS 150

G45524 BCH

A61094 B60927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G45524 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY BOY BUTLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Color of Parents | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1946

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Butler ?
13. Birthplace

MOTHER — 14. Maiden Name Butler ?
15. Birthplace

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 14 1946 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1946 at 12 07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 29 1946 to Nov. 4 1946 and that I last saw h[illegible] alive on Nov. 4 1946.

Immediate cause of death: PREMATURITY — Duration: LIFE

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature [signature] H. A[illegible]

Address JOHNS HOPKINS HOSP Date signed 11/4/46

VS 150

G15525 P.C. 9-61193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1157a

G15525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vickers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 6, 1946

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: William Vickers
13. Birthplace: Louisiana

MOTHER
14. Maiden Name: Lillian Harrody
15. Birthplace: Maryland

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School NOV 12 1946

18 (a) Funeral director: Commissioner of Health
(b) Address

NOV 14 1946 (Date rec'd by registrar) By: Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1946 at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1946 to Nov. 7 1946 and that I last saw her alive on Nov. 7 1946.

Immediate cause of death: hydrocephalus
multiple congenital anomalies — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Russell Jordan, M.D.
Address: Johns Hopkins Hospital Date signed: 11-7-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G45526
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 Ramsey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Ramsey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Ingrassia

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Ingrassia
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb 17 1880

8. AGE: Years 66 | Months 8 | Days 30 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name John La Grande
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Trippi
15. Birthplace Italy

16 (a) Informant Frank Ingrassia
(b) Address 1501 Ramsey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balt & B. M. Walther a.a. Co. Md

18 (a) Funeral director
(b) Address Pratt & Stricker Sts

19 (a) Nov 14 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1946 at 11 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946 to Nov 11 1946 and that I last saw her alive on Nov 10 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 48 Hrs.
Due to:
Due to Essential Hypertension — unknown
Other Conditions Generalized arteriosclerosis — unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Romani
Address 206 S Glenn St. Date signed 11-13-46 M. D.

VS 150

X

G45527 B.L. Q-61701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V161a

G45527 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline Sts.
(c) Hospital or institution: St. Joseph's 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Chase St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles August Bremer Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 / 11 / 46

8. AGE: Years	Months	Days	If less than one day
		½	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name Charles August Bremer
	13. Birthplace Fellowship W. Va
MOTHER	14. Maiden Name Myrtle Elizabeth Capp
	15. Birthplace Baltimore Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14 46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Cty Md

18 (a) Funeral director Wilmot Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 NOV 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1946, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1946, to 11/13 1946, and that I last saw him alive on 11/13 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Young
Address St. Joseph's Hosp. Date signed 11/13/46

G45528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G45528

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wabb Broadway.
(c) Hospital or institution: Church Home & Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Herbert Louis Willis

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1881

8. AGE: Years	Months	Days	If less than one day
65	9	6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Gardener
11. Industry or business Baltimore Com.

FATHER
12. Name Harry B. Willis
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Florence P Dickerson.
15. Birthplace Maryland. Eastern Shore

16 (a) Informant Mrs W. H. St Williams
(b) Address 1220 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

NOV 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1946, at 10 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946, to Nov. 13 1946, and that I last saw him alive on Nov. 13 1946.

Immediate cause of death Generalized. abdominal carcinomatosis — Duration 6 mos.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: Autopsy — Generalized abdominal Carcinomatosis — Autopsy: Yes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature David Barasch M. D.
Address Church Home & Hospital Date signed Nov 13 46

Barasch X

G45529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G45529 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 377 Hayward Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ella M. French

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 21, 1899

8. AGE: Years 58 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Glassboro N.J. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Balto. Public Schools

FATHER 12. Name deceased
13. Birthplace

MOTHER 14. Maiden Name deceased
15. Birthplace

16 (a) Informant Marguerette French
(b) Address 3917 Haywood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry N. Amuscat
(b) Address 4204 Reisterstown Ave

19 (a) (Date rec'd by registrar) (b) Huntington West Virginia, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1946 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1946 to 11/13 1946, and that I last saw her alive on 11/13 1946

Immediate cause of death: Intestinal Obstruction — Duration

Due to Carcinoma of the sigmoid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/9/46

Major findings of operation: Carcinoma of the sigmoid

of autopsy: Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lericka

Address St Agnes Hospital Date signed 11/13/46 M.D.

G45530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1124B

Registered No. G45530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4825 Bautelow ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4825 Bautelow ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard C Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~

6 (b) Name of husband or wife Annie Patricia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 — 1885

8. AGE: Years 61 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name Wesley Wade
13. Birthplace Balto Co Md.

MOTHER
14. Maiden Name Elizabeth Deering
15. Birthplace Balto Co. Md.

16 (a) Informant Annie P Wade
(b) Address 4825 Bautelow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16-46 (month) (day) (year)
(c) Cemetery or crematory Brid Ridge Cem
Location Pikesville Balto Co Md

18 (a) Funeral director Edward Toulson
(b) Address 1369 Wash Blvd

19 (a) Filed NOV 14 1946 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Nov 1946 10.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Nov. 1946. and that I last saw him alive on 12 Nov. 1946.

Immediate cause of death: Pulmonary Edema Bronchopneumonia — Duration: 1 day 1 day

Due to Cirrhosis of liver — 5 yrs

Due to

Other Conditions Chronic Syphilitis Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Baylus M. D.
Address 1600 Wilkens Ave Date signed 14 Nov 46

Williams, M.D.

G45531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G45531
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr George Stey

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Separated

6 (b) Name of husband or wife Mrs Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1875

8. AGE: Years	Months	Days	If less than one day
71	6	3	7 hr. 22 min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Service station attendant
11. Industry or business —

FATHER
12. Name George Stey
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Yakel
15. Birthplace Germany

16 (a) Informant Mrs Bertie S Roth
(b) Address 2312 East North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md

18 (a) Funeral director Langdon Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) Livingston Williams, M.D. Registrar

NOV 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-1946, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1946 to Nov 14 1946, and that I last saw h[illegible] alive on 11-13 1946.

Immediate cause of death	Duration
Uremia	
Due to Cerebral Vascular Accident	
Due to Hypertension and Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

73. Signature Norman R. Freeman Jr. M. D.
Address Union Memorial Hosp Date signed Nov 14 1946

G45532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G45532
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4209 Roland Avenue
(c) Hospital or institution:

27-F

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 Roland Avenue (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mary Washington Stewart

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1857

8. AGE: Years	Months	Days	If less than one day
88	11	24	--hr. --min.

9. Birthplace Oxford, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Postal Mistress

FATHER
12. Name James Stewart
13. Birthplace Oxford, Maryland

MOTHER
14. Maiden Name Matilda Bowdle
15. Birthplace Oxford, Maryland

16 (a) Informant Mrs. Virginia H. S. Fisher
(b) Address 4209 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)
(c) Cemetery or crematory Oxford
Location Oxford, Md.

18 (a) Funeral director H. O. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) NOV 14 1946 (b) [illegible] Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1946, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1946 to -- 19 --; and that I last saw h CX alive on Nov 12 1946.

Immediate cause of death — Duration

Old Age
Cerebral - Sclerosis
Due to General + Cerebral

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E Burns, M.D.
Address 1115 St Paul St Date signed 11/15/46

No. G45533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 142B

Registered No. G45533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Orleans Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 W. Fayrale St
(If no definite location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Jesse
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/10

8. AGE: Years	Months	Days	If less than one day
36	2	9	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Husband
(b) Address 523 W. Fayrale St

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof 11-15-46 (month) (day) (year)
(c) Cemetery or crematory Durham Cem.
Location Durham N. Carolina

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1946, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1946 to 11/12 1946 and that I last saw her alive on 11/12 1946.

Immediate cause of death	Duration
Ruptured Ectopic Pregnancy, Right	
Due to Hemorrhage, Shock	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/11/46
Major findings of operation: Ruptured Ectopic Pregnancy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry T. Walker Jr. M. D.
Address St. Joseph's Hosp Date signed 11/13/46

X

G15534 Died

AB-105920 BC# D61370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

G15534
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Knight-Twin B

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7-1946

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alexander Knight
13. Birthplace Va.

MOTHER
14. Maiden Name Dora Best
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11-12-1946 (month) (day) (year)
(c) ~~Crematory~~ crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) NOV 14 1946 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8- 1946, at 11.05 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1946 to 11-8 1946, and that I last saw h SE alive on 11-8 1946

Immediate cause of death: Asphyxia, Aspiration Amniotic Fluid — Duration: 1 day
Due to
Due to Breech - both twins breech
Other Conditions Hemoconcentration — 1 day
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin
Address Balt City Hosp Date signed Nov. 8 1946

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G15535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G15535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 S. Durham St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 103 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hildegarde Biebel

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Alois

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1865

8. AGE: Years 80 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ? Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name Jeany ?
15. Birthplace Germany

16 (a) Informant Louise Bridge
(b) Address 103 S. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Oppel's Sons
(b) Address Lombard & Bun St.

19 (a) NOV 14 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1946 at 2:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946 to Nov 13 1946. and that I last saw h[illegible] alive on Nov 12 1946.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Pittelman M. D.

Address 8 E. 7 Hamilton Ave Date signed Nov 13 1946

X

G15536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G15536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2330 No Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2330 No Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adolf J Maier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie

6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): June 6 1877

8. AGE: Years: 69 | Months: 5 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Germany

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Leopold Maier
13. Birthplace: Germany

MOTHER
14. Maiden Name: Minnie Herz
15. Birthplace: Germany

16 (a) Informant: Fannie Maier
(b) Address 2330 No Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-46 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address 1996 Balto St

NOV 14 1946 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1946 at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to 11-13 1946, and that I last saw him alive on 13 Nov. 1946.

Immediate cause of death: Carcinoma of Stomach — Duration 15 Mos.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 1945

Major findings of operations: Gastric Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. Greenwald M.D.

Address 721 - Medical Arts Bldg Date signed 11 Nov. 46

Baltimore 1 Md.

The G45537

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 157E

Registered No. G45537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED: Fredericktown
(a) State Md (b) County Mt Airy
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. Airy
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Herman Watkins Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, '46

8. AGE: Years	Months	Days	If less than one day
	1	16	hr. min.

9. Birthplace Frederick, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Herman Watkins
13. Birthplace Md

MOTHER 14. Maiden Name Dorothy Gaskell
15. Birthplace Md

16 (a) Informant Mrs Dorothy Watkins
(b) Address Mt Airy, Md

17 (a) Burial (b) Date thereof 11-16-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mayer Chapel
Location Plane 4 Frederick Co. Md

18 (a) Funeral director C. H. Waltz
(b) Address Westfield, Md.

19 NOV 14 1946 (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1946, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1946 to Nov. 14 1946, and that I last saw him alive on Nov 14 1946

Immediate cause of death Heart Failure — Duration

Due to Congenital Heart Disease

Due to

Other Conditions Sclerema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James V. Munro Jr. M. D.
Address Mercy Hosp Date signed 11-14-46

VS 150

X

G45538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

G45538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N. Port St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Edgar Scott Sr

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Carrie Mary

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1883

8. AGE: Years 63 | Months — | Days 8 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation produce dealer

11. Industry or business —

FATHER
12. Name Richard Franklin Scott
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie Elizabeth Ross
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Carrie Scott
(b) Address 508 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E. Preston St.

19 (a) Nov 14 1946 (Date rec'd by registrar) (b) Thurlington Williams Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946, at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— to 19—, and that I last saw him alive on — 19—.

Immediate cause of death: acute myocardial insufficiency — Duration 1 hr.
Due to: carditis — ?
Due to: infectious arthritis as a youth
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Stitzel
Address 447 N. Kenwood Ave. Date signed 11/14/46
Howard J. Masters, M.D.

VS 150

G45539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V163H

G45539
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Richmond Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Brockoff

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Geo H Brockoff
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 31, 1885

8. AGE: Years	Months	Days	If less than one day
61	5	13	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Lawrence Friskey
13. Birthplace Md

MOTHER
14. Maiden Name Dont Know
15. Birthplace Md

16 (a) Informant Geo H Brockoff
(b) Address 3314 Richmond Ave

17 (a) Burial (b) Date thereof Nov 16
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem Co
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 14 1946 (b) Interring or Witnessing
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1946, at 2:08 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/13/46 at 1 P. M.
(b) Where did injury occur? 3314 Richmond ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Open gas unlighted gas range

23. Signature Howard J. Chaillon M.D.
Medical Examiner.
Date signed 11-13-46

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

St. Mary's Church, 5500 York Rd.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1946

Registered No. G25510

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unidentified

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 14 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1946, at 4.45 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Negligence and Exposure, Malnutrition, and abrasion

Due to Probable homicide

Other Conditions (none)

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 10-23-46 at M.
(b) Where did injury occur? Found St. Mary's Church 5500 York Road
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Neglect of newborn

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10/24/46

X 478

G15511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1159

Registered No. G15511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Hucker Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Hucker Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1946

8. AGE: Years Full term | Months | Days | If less than one day: hr. 1 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Henry Douglas
13. Birthplace Newberg, S.C.

MOTHER 14. Maiden Name Norris Douglas
15. Birthplace Newberg, S.C.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 14 1946 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

29. DATE OF DEATH October 9, 1946, at 8:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Spontaneous abortion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. L. Merrill M.D. Medical Examiner.
Date signed 10/10/46 Per H. J. Mullen, M.D.

G15512 B.C.9-61044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G15512 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby J Eva Dean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balto. md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hilliard Dean

13. Birthplace Columbia S.C.

MOTHER 14. Maiden Name Eva Douglas

15. Birthplace Blythewood S.C.

16 (a) Informant Eva Dean

(b) Address 414 Robert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 14 1946

18 (a) Funeral director Commissioner of Health

(b) Address

NOV 14 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 30 - 1946 at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1946, to 10-30 1946, and that I last saw him alive on 10-30-1946.

Immediate cause of death — Duration

Due to pneumaturity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maybelle L. Weaver M. D.

Address 1944 Druid Hill Ave Date signed 11-1-46

VS 150

X

G45513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46F

Registered No. G45513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 118 days
(e) Length of stay in Baltimore (yrs., mos., or days) 118 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 E. 127th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Davis, Clarence

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race colored

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Pinky Brown

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1905

8. AGE: Years 41 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Charleston, S.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Ben Davis
13. Birthplace Charleston, S.C.

MOTHER
14. Maiden Name Ida ?
15. Birthplace Charleston, S.C.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 15 46 (month) (day) (year)
(c) Cemetery or crematory Bath National Cem
Location Baltimore Md

18 (a) Funeral director Sarah A Brown Son
(b) Address 1018 Montgomery Street

(a) (b) Registrar

NOV 15 1946

NOV 15 1946 Smith Lee Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946 at 3:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946 to Nov. 11 1946 and that I last saw him alive on Nov. 11 1946

Immediate cause of death Carcinoma, liver, metastatic with intrahepatic obstruction of common bile duct — Duration 4 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G45544 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Md
(b) Street address 1421 Poplar Grove
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Poplar Grove (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Leon Piet Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 2/120695-2

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Pearl Katharyn M. Moog

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1874

8. AGE: Years 72. | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Bolton Md. (City or county, and state)

10. Usual Occupation Retired Bookkeeper.

11. Industry or business

FATHER 12. Name Wm. G. Piet

13. Birthplace Martinsburg W-Va

MOTHER 14. Maiden Name Mary S. Butler

15. Birthplace Hagerstown Clerk

16 (a) Informant Thomas Leon Piet Jr.

(b) Address 1421. Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto Md

18 (a) Funeral director Henry B. Cunningham Son

Address 2214. Edmondson Ave

NOV 15 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1946, at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945, to Nov 12 1946 and that I last saw h[illegible] alive on Nov 9 1946

Immediate cause of death: Cerebral hemorrhage

Due to Arteriosclerosis. Terminal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration: 7

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Chrysant M.D.

Address 3717 Woodbine Ave Date signed Nov 14/46

VS 3

G45545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92B

Registered No. G45545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2823 The Alameda
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 The Alameda (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. Killmond

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 216-01-0249

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie Killmond
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 5, 1876

8. AGE: Years	Months	Days	If less than one day
70	1	9	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Lumberman
11. Industry or business Marine Guard Service

FATHER
12. Name John M. Killmond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Laura V Mills
15. Birthplace Baltimore. Md.

16 (a) Informant Mrs W H Hecker (daughter)
(b) Address 1640 Shadyside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Forhyn
Location Forestville Md

18 (a) Funeral director William Cook Jr
(b) Address 1867 Pont St

19 NOV 15 1946 (Date rec'd by registrar) (By) Hunter for Williams Asst

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946, at 6 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1946 to Nov 14 1946 and that I last saw h[illegible] alive on Nov 13 1946

Immediate cause of death	Duration
Coronary Thrombosis	20 Min.
Due to Decompensated Mitral leg	1 yr.
Due to Hypertension Arteriosclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. F. A. Stevens M. D.
Address 3818 Harford Rd Date signed 11-14-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45546

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 845 N Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 845 N Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E Wagner

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr 4, 1876
8. AGE: Years 70 | Months 7 | Days 10 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Philip Wagner
13. Birthplace Md

MOTHER
14. Maiden Name Margaret (Unknown)
15. Birthplace Germany

16 (a) Informant Charles H Wagner
(b) Address 113 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilbur Cohen
(b) Address 1219 E Fort Ave

19 (a) NOV 15 1946 (Date rec'd by registrar) (b) Huntington Hilli... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1946, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Nov — 1946, and that I last saw h... alive on about Oct 1946.

Immediate cause of death: Myocardial Insufficiency — Duration: 2 wks. Days
Due to: Arteriosclerotic CVD — years
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. Highstown M. D.
Address 888 N. Lombard St Date signed 11-14-46

VS 150

X

The G15517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 W 25th St
(c) Hospital or institution: 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 W 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Offerman

3 (b) If veteran, name war: W
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 21 1879
8. AGE: Years 67 Months 7 Days 23 If less than one day hr. min.
9. Birthplace: New York N.Y. (Town, county, and state)
10. Usual Occupation: Hat Trimmer
11. Industry or business:

FATHER
12. Name: Frederick Offermann
13. Birthplace: Germany

MOTHER
14. Maiden Name: Josephine Katenhorn
15. Birthplace: New York N.Y.

16 (a) Informant: Emma Offerman
(b) Address: 324 E 27th St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11 16 46 (month) (day) (year)
(c) Cemetery or crematory: Woodland
Location: Baltimore Co Md
18 (a) Funeral director: Wilhelm Colvin Inc
(b) Address: 1217 E Fayette St
19 NOV 15 1946 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946 at 12 15 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13. 1946. to Nov. 14 1946 and that I last saw him alive on Nov. 14 1946.

Immediate cause of death: Coronary Occlusion — Duration: immediate

Due to Arterio-Sclerosis — Duration: years

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Frank M. Ogden M. D.
Address 2701 N. Calvert St Date signed Nov. 15 1946

VS 150

G45548 · BALTIMORE CITY HEALTH DEPARTMENT · G45548

CERTIFICATE OF DEATH

9402 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 S Woodyear St
(c) Hospital or institution:
19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 S Woodyear St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J Clark

3 (b) If veteran, name war WWI
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1894

8. AGE: Years 52 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer Domestic

11. Industry or business City of Baltimore

FATHER 12. Name Thomas Clark

13. Birthplace Anne Arundel Co Md

MOTHER 14. Maiden Name Evelina Conaway

15. Birthplace Anne Arundel Co Md

16 (a) Informant Helen I Clark

(b) Address 304 S Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)

(c) Cemetery or crematory U.S. National
Location Balto. Md

18 (a) Funeral director Pilhorn Corkran

(b) Address 1217 ft Fond St

19 (a) NOV 15 1946 (Date received by local registrar) (b) Huntington Williams, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946, at 4:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1946, to 11/14 1946, and that I last saw h[illegible] alive on 11/14 1946.

Immediate cause of death: Coronary occlusion — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 Wilkens ave Date signed 11/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45519 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27-5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura May Beebe

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W	NILE	Female	White	Widowed

6 (b) Name of husband Frank C. Beebe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14th 1868

8. AGE: Years	Months	Days	If less than one day
78 75	8 5	29	hr. min.

9. Birthplace Ellicott City (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER 12. Name John W. Webb
13. Birthplace Ellicott City, Md.

MOTHER 14. Maiden Name Anybell Owings
15. Birthplace Ellicott City Md.

16 (a) Informant Records
(b) Address Methodist Home for Aged

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

Date rec'd NOV 15 1946 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13th 1946, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1946 to Nov 13 1946, and that I last saw h[illegible] alive on Nov 13 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 6 hrs
Due to Arteriosclerosis — 20 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 800 W 32nd St Date signed 11-14-46

VS 150

G45550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

Registered No. G45550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 E. 25th ST. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME IRELAND, MRS. MARTHA MARIE

3 (b) If veteran, name war	3 (c) Social Security Account No.
— W	— NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED.

6 (b) Name of husband or wife Thomas Hoole Ireland
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 6, 1890

8. AGE: Years	Months	Days	If less than one day
56yrs	10	7	hr. min.

9. Birthplace Stoyestown Somerset County, Pa. (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business —

FATHER
12. Name Mr Frank Taylor
13. Birthplace Stoyestown, Somerset County
MOTHER
14. Maiden Name Ellen — (Ellen Knavel) Pa.
15. Birthplace Stoyestown Pa.

16 (a) Informant Mr. Carl Smith (son-in-law)
(b) Address 836 Park Ave. Balto, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows
Location Stoyestown Pa.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946, at 4 p. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1946, to Nov. 13 1946, and that I last saw her alive on Nov. 13 1946.

Immediate cause of death: CEREBRO VASCULAR ACCIDENT — Duration 4 HRS.
Due to HYPERTENSIVE CARDIO - VASCULAR DISEASE.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address Union Mem. Hosp. Date signed 11-18-46

G45551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G45551 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1834 N Chester Street
(c) Hospital or institution: 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 N Chester St (If rural give location)
(e) If foreign born, how long in U. S. A.? Life years

3 (a) FULL NAME William Cameron Booze

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Johnnetta M Booze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1901

8. AGE: Years 45 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Recreation Center Leader
11. Industry or business Balto City

FATHER
12. Name James H Booze
13. Birthplace Balto Md

MOTHER
14. Maiden Name Katherine H Martin
15. Birthplace Balto Md

16 (a) Informant Mrs Johnnetta M Booze
(b) Address 1834 N Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave & Rose St

18 (a) Funeral director Albert L Hill Jr
(b) Address 1806 N Chester Street

19 (d) NOV 15 1946 (Date received by registrar) Certificate for William Booze registered

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/1942 to 11/13/1946, and that I last saw him alive on 11/13/1946.

Immediate cause of death: Respiratory Failure — Duration: 1 day
Due to Carcinoma of Stomach — 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A Weisa M. D.
Address 1927 E. North Ave. Date signed 11-14-46

VS 2

G35552

JL - 105910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 1-1
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Suphire Albers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1884

8. AGE: Years	Months	Days	If less than one day
62	6	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Hausman
13. Birthplace Md.

MOTHER
14. Maiden Name Healthy Shaw
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East End of North Ave.

18 (a) Funeral director Tull & Zeiler Co.
(b) Address 1603 N. Wolfe St.

19 (a) Date rec'd by registrar (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1946, at 7:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1946 to Nov. 13 1946 and that I last saw h 8F alive on Nov. 13 1946.

Immediate cause of death
Uremia
Due to Pyelonephritis, acute,
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operations
of autopsy Pyelonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Doyle Waldron M.D.
Address B. C. H. Date signed 11/14/46

VS 150

133a

G45553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G45553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS FINE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife SARAH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation Mfg. SOFT DRINKS

11. Industry or business

FATHER 12. Name MENDEL

13. Birthplace RUSSIA

MOTHER 14. Maiden Name HINDA

15. Birthplace RUSSIA

16 (a) Informant HOSPT RECORDS

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-15-46 (month) (day) (year)

(c) Cemetery or crematory BETH TEFILOH

Location Windsor Mill Rd

18 (a) Funeral director Jack Levy Inc.

(b) Address 1439 E Baltimore St

19 NOV 15 1946 (Date rec'd by registrar) [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1946, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/46 19 . to 11/14/46 19 , and that I last saw him alive on 11/14/46 19

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Malignant Hypertension — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Dona

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 11/14/46 M. D.

VS 150

driving Rother X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G45554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 348 Broadmoor Rd.
(c) Hospital or institution: 27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 348 Broadmoor Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. BURKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Henry Burke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1866

8. AGE: Years	Months	Days	If less than one day
80	6	21	hr. min.

9. Birthplace Loda, Ill.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Meyer
15. Birthplace Germany

16 (a) Informant Mrs. William A. Snyder
(b) Address 348 Broadmoor Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago, Ill.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 15 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1946, at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1946, to Nov 14 1946, and that I last saw h[illegible] alive on Nov 14 1946.

Immediate cause of death: Hypostatic pneumonia 1 day — Duration

Due to

Due to: Malignant cyst removed

Other Conditions 7 yrs ago

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 734 N. Patterson Pk. Date signed Nov 15 1946

VS 150

G45555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G45555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19-2
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 W. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Welsh

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mildred H. Welsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1889

8. AGE: Years	Months	Days	If less than one day
57	7	17	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Restaurant Manager
11. Industry or business Gefglers

FATHER
12. Name Patrick J. Welsh
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ellen Needham
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Flock, daughter
(b) Address 4615 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 15 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-46 19 at 5 10 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-14-46 at 5 A. M.
(b) Where did injury occur? 1602 W. Baltimore st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self-inflicted gun shot.

23. Signature Thomas J. Mackin M.D. Medical Examiner.
Date signed 11-14-46

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information required is extremely important. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G45556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 St. Johns Rd.
(c) Hospital or institution:

27-B

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 St. Johns Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. JESSE SIDWELL MYERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith Nourse Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1873

8. AGE: Years	Months	Days	If less than one day
73	7	11 12	hr. min.

9. Birthplace New Windsor, Md.
(Town, county, and state)
10. Usual Occupation D. D. S.
11. Industry or business

FATHER
12. Name John W. Myers
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Alice Sidwell
15. Birthplace Frederick Co., Md.

16 (a) Informant Mrs. Edith N. Myers
(b) Address 632 St. Johns Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 15 1946 (b) Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1946, at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Nov 12 1946
and that I last saw him alive on Nov 12 1946.

Immediate cause of death: Melanotic Sarcoma — Duration: 8-10 Mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Hasky M. D.
Address 1403 Park Ave Date signed 11/13/46

8

x 17

G45557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 742 W. Redwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 742 W. Redwood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE SUTER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1893

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	8	29		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Chase
15. Birthplace Md

16 (a) Informant Mary Wright (Daughter)
(b) Address 742 Redwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G.Cooper
(b) Address 510-12 N.Carrollton Ave

19 (a) NOV 15 1946 (Date received by Local Registrar) (b) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1946, at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1946 to Nov 13 1946 and that I last saw h alive on Nov 13 1946.

Immediate cause of death	Duration
(a) Acute Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dan'l Swander M. D.
Address 1424 Lee Date signed 11/15/46

VS 150

G45558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G45558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Chapel st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Dix

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Raymond Dix
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 6, 1890

8. AGE: Years: 56 52 | Months: 6 | Days: 109 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: George Benzing
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Welsch
15. Birthplace: Germany

16 (a) Informant: Raymond Dix
(b) Address: 102 S. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/18/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: W. W. E. Dippel's Sons
(b) Address: Lombard & Ann Sts.

19 (a) NOV 15 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14th 1946, at 11-50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture skull
Intracranial hemorrhage
Contusion of brain
Fracture right femur
Gangrene rt. leg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 2/1
(a) Date of injury 11-8-46 at 9-30 A.M.
(b) Where did injury occur? Wolfe & Pratt Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by truck.

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 11-15-46

VS 151

X

Please write plainly, with ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a ✓

Registered No. G45559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 N. Patterson Park Ave.
(c) Hospital or institution: 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNA MAY FRATANA (FRATANTUONO)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or ~~wife~~ Frank L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1880

8. AGE: Years	Months	Days	If less than one day
65 yrs.	11	19	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Winters
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Husband
(b) Address 903 N. Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or ~~Crem~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Huntington Williams M.D. (Date received by registrar) Registrar

NOV 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/46 19 at 2:10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Nov. 14 1946 and that I last saw h[illegible] alive on Nov 14 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	7 hrs
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Cohen M. D.
Address 1761 E Monument Date signed 11/16/46

X

G45560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G45560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 N. Asquith st. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Douglas Jr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Pauline Douglass
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) June 1900

8. AGE: Years	Months	Days	If less than one day
46	5	-	hr. min.

9. Birthplace Rollins North Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Matthew Douglass Sr.
13. Birthplace Rollins North Carolina

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Pauline Douglass
(b) Address 104 N. Asquith st

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 15-46 (month) (day) (year)
(c) Cemetery or crematory
Location Rowland North Carolina

18 (a) Funeral director Mozella Bailey
(b) Address 1421 E. Jefferson st.

19 NOV 15 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1946, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1946. to Nov 13 1946
and that I last saw him alive on Nov 13, 1946:

Immediate cause of death	Duration
Pulmonary hemorrhage	
Due to Possible Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Pulmonary Hemorrhage type lung Could be of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruben Simonski M. D.
Address 1400 Hoyt. Date signed 11-15-46

VS 150

Melvin Jaworskix

G45561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. G45561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Buard st
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Buard st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Mathews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Lillian Maddley
(b) Address 1505 Buard Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy P. Wilson
(b) Address 1700 Bentalou ave

19 Date received NOV 18 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

11/12/46

20. DATE OF DEATH 11/14/46 19 7:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/24/46 19 to 11/14/46 and that I last saw him alive on 11/12/46

Immediate cause of death (a) Uremia

Due to (b) Chronic A. Nephritis

Due to (c) Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Lee Ellis, M.D.
Address [illegible] Date 11/15/46

VS 150

G45562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G45562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 E. Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 E. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus a Watts Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Mary C. Kittleband

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 1874

8. AGE: Years	Months	Days	If less than one day
72	9	18 19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business

FATHER
12. Name Albert Watts
13. Birthplace Md

MOTHER
14. Maiden Name Sophie Weller
15. Birthplace Md

16 (a) Informant Mrs Mary C Watts
(b) Address 221 E. Fulton Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 18 '46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Rd

18 (a) Funeral director Harry N Withe
(b) Address 4101 Edmondson Ave

19 NOV 15 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 19 to Nov 14 19 46, and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 3 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert H Katz M. D.
Address 2010 Eutaw Pl Date signed Nov 15 1946

VS 150

G45563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163E

Registered No. G45563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 W. Baltimore Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hosp Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/15/46 (month) (day) (year)
(c) Cemetery or crematory
Location Sparta N C.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) NOV 15 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1946, at 3.50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strychnine poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-14-46 Ht. P. M.
(b) Where did injury occur? Central Hotel-Paca & Fayette Sts.
(c) Did injury occur at home, on farm, industrial place, in public ~~place~~? public While at work? No
(d) Means of injury Ingestion of strychnine.

23. Signature George G. Merrill M.D.
Date signed 11-15-46 Medical Examiner.

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45564 D.C. g. 61529 G45564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1610 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 N. Mount St DOA
(c) Hospital or institution:
19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Newberry, S. C.

MOTHER
14. Maiden Name Alice Crotwell
15. Birthplace Newberry, S. C.

16 (a) Informant John Williams
(b) Address 213 N. Mount St

17 (a) Burial (b) Date thereof Nov. 15, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2320 N. Schroeder St

NOV 15 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1946, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fahlbusch M.D.
Medical Examiner.
Date signed 11/12/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15565 AB-103809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G15565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 13-3
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2months- 26days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2443 Etting St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ellis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Mabel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19- 1879

8. AGE: Years	Months	Days	If less than one day
67	4	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Robert Ellis
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillie Bailey
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 16-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 412 E Preston St
NOV 15 1946 (Date rec'd by registrar) (By)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12- 1946, at 10.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1946 to 11-12 1946 and that I last saw h im alive on 11-12 1946

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Bird M. D.
Address Balto City Hosps Date signed 11-12-46

VS 150

G5566 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 62a ✓ — Registered No. G45566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — 27-4
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Historia Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Schertle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Charles G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-28-1880

8. AGE: Years 66 | Months 2 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace: Germany (Town, county and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name ✓ YAHN
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant: Mrs. William Schertle
(b) Address: 3210 Historia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-46 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Baltimore

18 (a) Funeral director: Longnecker & Luck
(b) Address: 530 E. Hartford Rd.

(Date received by Registrar) NOV 15 1946 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1946, at 11.15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Thyrotoxic heart disease

Due to: Nodular Goitre

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 11/14/46

Please write the causes of death clearly and legibly. Age is especially important. Physicians: please write

VS 191

G45567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G45567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-8
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3425 E. Pratt st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Bilz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24-1892

8. AGE: Years 54 | Months 2 | Days 20 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Bilz
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ruhrman
15. Birthplace Balto Md.

16 (a) Informant Margaret Estep
(b) Address 308 S. [illegible] Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director John A. Miller
(b) Address 2134 Jefferson St.

19 (a) NOV 15 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13-1946, at 7 30 P.M.

21. I certify that I took charge of the remains described above, **held an** Insp & Aut. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpas M.D.
Medical Examiner.
Date signed 11-14-46

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

Registered No. G15568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Janney St.,
(c) Hospital or institution: 26-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 S. Kresson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Kozny

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Leonard O. Kozny.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1881

8. AGE: Years	Months	Days	If less than one day
65	0	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Matthew Reisinger
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericka Grindall
15. Birthplace Germany

16 (a) Informant Leonard O. Kozny
(b) Address 30 S. Kresson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) NOV 15 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1946 19 . at 5:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 42 to 11/14 19 46 and that I last saw h e alive on 11/14 19 46

Immediate cause of death Cerebral Hemorrhage Duration

Due to Hypertension & Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles A. Cowe
Address 3215 Eastern Av Date signed 11/16/46

VS 150

G15569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G15569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N Port St
(c) Hospital or institution: 6-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Machan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30-1874

8. AGE: Years	Months	Days	If less than one day
72	2	14	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Priety
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Genant
15. Birthplace Germany

16 (a) Informant Mrs Bertha Del Vigo
(b) Address 1006 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location City

18 (a) Funeral director Ellerich Funeral Home
(b) Address 2008 Orleans St

19 Filed NOV 19 1946 Huntington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1946, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Nov 13 1946 and that I last saw h[illegible] alive on Nov 11 1946

Immediate cause of death: Hypostatic Congestion — Duration: 3 yrs
Due to: Arteriosclerosis
Due to:
Other Conditions: Coronary Thrombosis — 2 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elbert C Stansbury, M.D.
Address 5939 Reisterstown Rd Date signed Nov 14 1946

VS 150

G35570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G35570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Unetta Ave.
(c) Hospital or institution: 25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Unetta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN F. RUPPERT

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-8626

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Clara Ryder Ruppert
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 30, 1882

8. AGE: Years	Months	Days	If less than one day
64	3	13	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business St Timothys School

FATHER
12. Name Martin Ruppert
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary C. Glaeser
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Clara Ryder Ruppert
(b) Address 801 Unetta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 16 Nov. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director W. B. Shilbert & Son
(b) Address 1300 Eutaw Place

19 (a) Date received NOV 16 1946 (b) Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 November 1946 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1943 to Nov 12 1946 and that I last saw h[illegible] alive on Nov. 11 1946

Immediate cause of death: Carcinoma, Stomach — Duration 3/4 yr.
Due to 1,
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Aug 1 46
Major findings of operation Cancer-Stomach,
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Lloyd Johnson M. D.
Address Catonsville Md. Date signed 11-19-46

VS 150

G45571

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G45571
CERTIFICATE OF DEATH 55E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NC. (b) County
(c) City or town Spray
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 464
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Hawkins, Buford Lee

3 (b) If veteran, name war --

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1927

8. AGE: Years 19 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Spray, NC
(Town, county, and state)

10. Usual Occupation Deckhand

11. Industry or business Seafarer

FATHER
12. Name Ike Hawkins
13. Birthplace Stokley, NC

MOTHER
14. Maiden Name Elsie Bryant
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 '46 (month) (day) (year)
(c) Cemetery or crematory
Location Leaksville N.C.

18 (a) Funeral director Walter T. Schwarzauer
(b) Address 1126 W Lorst St.

19 (a) NOV 15 1946 (Date received by Registrar) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1946, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1946, to Nov. 15 1946, and that I last saw him alive on Nov. 15 1946.

Immediate cause of death Reticulum cell lymphosarcoma of left cervical lymph nodes with pulmonary metastasis and hemorrhage — Duration 11 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank B. Snell
Frank B. Snell, Asst. Surgeon (R) M. D.
Address US Marine Hospital Date signed 11/16/46
Balto, 11, Md.

VS 180

1-Transcript

G45572

HEALTH DEPARTMENT—CITY OF BALTIMORE

G45572

CERTIFICATE OF DEATH

S.S.# 705-05-2126

1. PLACE OF DEATH 20-8

CITY OF BALTIMORE: (No. 235 - S. Loudon Ave Ward) 1310

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME John Thomas Cadogan

(a) Residence: No. 235 South Loudon Ave Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Theresa

6. DATE OF BIRTH (month, day, year) Nov 29-1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	11	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. B&O.R.R.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Boiler Maker

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Walter P. Cadogan

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Ellen Singleton

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Mary T. Cadogan

(Address) 235 S. Loudon Ave

18. BURIAL, CREMATION, OR REMOVAL

Place New Cathedral Date Nov 16 1946

19. UNDERTAKER Thomas F. Kenney Inc

(Address) Hoelins & Gilmor Sts.

20. FILED NOV 15 1946 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 13, 1946

22. I HEREBY CERTIFY, That I attended deceased from May 1943 to Nov. 13 1946

I last saw him alive on Nov. 12, 1946 Death is said to have occurred on the date stated above, at 8:00 a.m.

The principal cause of death and related causes of importance were as follows:

Uremia — Date of onset December

Other contributory causes of importance:

Cardio-Renal Vascular Disease — May 1943

Was an operation performed? ... Date of ...

For what disease or injury? ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) Eliot W. Johnson M. D.

(Address) 343 E. Druid Hill Ave

X

G45573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G45573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4716 Ivan Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emory M. Cowman (Emory William Cowman)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 577-16-0457

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva Cowman

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 10 - 21 - 80

8. AGE: Years 66 | Months 0 | Days 24 | If less than one day: hr. min.

9. Birthplace Md (Balto.)
(Town, county, and state)

10. Usual Occupation Lab. Clerk

11. Industry or business Miller Reed Hospital

FATHER
12. Name Albert Cowman
13. Birthplace Md

MOTHER
14. Maiden Name Anna Fisher
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-16-46 (month) (day) (year)
(c) Cemetery or crematory Govans Presby. Cem.
Location Balto. Md.

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W North Ave.

19 (a) (Date received by local registrar) (b) [illegible] for William H. Hill

NOV 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946 at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1946 to Nov. 13 1946 and that I last saw him alive on Nov. 13 1946.

Immediate cause of death: Generalized carcinomatosis — Duration: 18 mos.

Due to: Carc. Stomach

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation August 1945

Major findings of operation Inoperable Carcinoma Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Dingman M. D.
Address 1111 11/14/46 Date signed

X

G45571
B.C. B-6172?

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

✓ B-45574 ~~B-45571~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 N Carolina St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Carolina St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8th 1946

8. AGE: Years	Months	Days	If less than one day
			4 hr. 30 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Davis
13. Birthplace Columbia S.C.

MOTHER
14. Maiden Name Bettie Ferguson
15. Birthplace Bowling Green Va

16 (a) Informant Bettie Davis (mother)
(b) Address 423 N. Carolina St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 15 1946 Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 15 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1946, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8th 1946 to Nov 8th 1946, and that I last saw h[illegible] alive on Nov 8th 1946.

Immediate cause of death: Asphyxia Monoxium — Duration 4 hrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred A. Lapook
Address 422 N. Bond St Date signed 11/9/46 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 9-2-49

G45575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G45575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 Bedford Place
(c) Hospital or institution: none 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Bedford Place (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Annette Agnus Leser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Oscar Leser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1871

8. AGE: Years	Months	Days	If less than one day
75	4	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Felix Agnus
13. Birthplace France

MOTHER
14. Maiden Name Anne E. Fulton
15. Birthplace Georgetown, (Va.) D.C.

16 (a) Informant Judge Oscar Leser
(b) Address 4403 Bedford Place

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director [redacted] John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

NOV 15 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1946 to Nov 14 1946 and that I last saw h[illegible] alive on Nov 14 19

Immediate cause of death: Coronary Thrombosis — Duration: 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H Pearce M. D.
Address 2105 N. Charles St. Date signed Nov 15/46

VS 150

X

G15576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G15576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 12-C
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Brandy

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	212-16-6937	M.	W.	M.

6 (b) Name of husband or wife Margaret Bross Brandy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1880

8. AGE: Years	Months	Days	If less than one day
66	5	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business New York Loan Co.

FATHER
12. Name John Cromwell
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah Brandy
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Margaret G. Brandy
(b) Address 2822 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 15 1946 Huntington Williams, M.D.
(b) Date received (Registrar) (c) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1946, at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1946 to 11/14 1946, and that I last saw h alive on 11/14 1946.

Immediate cause of death brain damage(?) — Duration

Due to cerebral trauma

Due to accident

Other Conditions nasal hemorrhage
fracture of nasal bones.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1 1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11/13/46 at 6 P. M
(c) Where did injury occur? Balto. Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? in public place While at work? No
(Specify type of place)
(e) Means of injury Tripped on curb while running.

23. Signature C. W. Lyerly M. D.
Address Univ. Hosp. Date signed 11/15/46

Howard J. Maddis MD /per L.G. Merrill MD

G45577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

Registered No. G45577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave.
(c) Hospital or institution: Colonial Nursing Home 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME TURNER A. ROSS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Maggie A. Ross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1877

8. AGE: Years	Months	Days	If less than one day
69	2	28	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER | FATHER
12. Name Charles Ross
13. Birthplace N. Y.
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Walter E. Ross
(b) Address 7110 Wardman Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/46 (month) (day) (year)
(c) Cemetery or crematory Poplar Springs Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 15 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1946, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov. 14 1946 and that I last saw him alive on 11-13 1946

Immediate cause of death: Pulmonary edema — Duration
Due to: Pulmonary Tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Schreyer
Address 3021 EDMONDSON AVE. H. W. SCHREYER, M. D.
BALTIMORE 29, MD.
Date signed 11-15-46

G45578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-3a

Registered No. G45578

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Castle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Castle Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARYANNA KWIATKOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Martin
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) February 2, 1879

8. AGE: Years	Months	Days	If less than one day
67	9	12	hr. min.

9. Birthplace Kalisz, Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Winiarski
13. Birthplace Kalisz, Poland

MOTHER
14. Maiden Name Antoinette Kujawa
15. Birthplace Kalisz, Poland

16 (a) Informant Mr. Martin Kwiatkowski
(b) Address 208 S. Castle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address Eastern Avenue

NOV 16 1946
(Date rec'd by registrar)

19 (a) Embalmer Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1946 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1943 to Nov 14 1946 and that I last saw h[illegible] alive on Nov. 14 1946. Age 46

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 11/14/46

Due to ARTERIAL HYPERTENSION — 5/18/43

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Wenga
Address 209 S. Castle Str Date signed 11/15/46

VS 190

G45579 | BALTIMORE CITY HEALTH DEPARTMENT | G45579

CERTIFICATE OF DEATH

937 | Registered No.

please write the causes of death clearly and legibly. Physicians: please see that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days) Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Myrtle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA WILSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1903

8. AGE: Years: 43 | Months: 1 | Days: 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles B. Jones
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lydia Hooper
15. Birthplace Baltimore, Md

16 (a) Informant Nathan S. Wilson
(b) Address 1111 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Rev. Geo. A. Holland
(b) Address 1691 Druid Hill Ave

19 (a) NOV 16 1946 Huntington Williams, M.D.
Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/46 19 , at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to: Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11/14/46

G45580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 77c

G45580 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 767 Bradley st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Randolph Garrett (Jackson)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1902

8. AGE: Years 44 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Towson (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Garrett
13. Birthplace Towson, Md.

MOTHER 14. Maiden Name Margaret Garrett
15. Birthplace Towson Md.

16 (a) Informant Mary Jordon
(b) Address 767 Bradley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest.
Location Towson Md.

18 (a) Funeral director Mrs. Georgia A. Hall Coombs
(b) Address 1631 Druid Hill Ave

19 NOV 16 1946 (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14- 1946, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Alcoholism

Due to

Other Conditions Acute Congestive Cardiac Failure.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Claudius M.D. Medical Examiner.
Date signed 11-14-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G45581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write t... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 Dallas St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Doris Stokes Studivent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Obie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1915

8. AGE: Years 30 | Months 10 11 | Days 15 16 | If less than one day hr. min.

9. Birthplace Gloucester Co. Va
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Public school

FATHER
12. Name Floyd Stokes
13. Birthplace Gloucester Co. Va

MOTHER
14. Maiden Name Kate Buckner
15. Birthplace Gloucester Co. Va

16 (a) Informant Obie M. Studivent
(b) Address 234 Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1946 (month) (day) (year)

(c) Cemetery or crematory Lee Hall, Va.
Location Gloucester Co. Va

18 (a) Funeral director Mrs. Lucy A. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) NOV 16 1946 (Date rec'd by registrar) Huntington Williams (Registrar) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1946, at 6:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1946 to 11-14 1946 and that I last saw h ~~e~~ alive on 11-14 1946.

Immediate cause of death	Duration
Generalized Peritonitis	12 days
Due to Pelvic Infection	
Due to	
Other Conditions Paralytic Ileus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Franklin Phibbs M.D.

Address 1543 Penna Ave Date signed 11/14/46

VS 150

G15582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G15582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N. Appleton St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite Marguerite E. Dell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife John H. Dell
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) March 12, 1913

8. AGE: Years	Months	Days	If less than one day hr.	min.
33	8	2		

9. Birthplace Woodlawn, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Fred Schissler
13. Birthplace Woodlawn, Md.

MOTHER
14. Maiden Name Sarah Hidey
15. Birthplace Woodlawn, Md.

16 (a) Informant Mr. John H. Dell
(b) Address 809 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Wallis Lamoreau
(b) Address 4610 Liberty Heights Ave.

NOV 16 1946 (Date received) (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 14 1946, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1946 to 11-14 1946 and that I last saw her alive on 11-14 1946.

Immediate cause of death: Acute ry. side heart failure — Duration

Due to Generalized Peritonitis

Due to intestinal obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/24/46; 11/10/46

Major findings of operation: gangrenous intestine & obstruction

of autopsy: as above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E Miller, M.D.
Address Maryland Gen'l. Hosp. Date signed 11/14/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G45583
AB-103513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G45583
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jamie Mae Richburg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Timothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14- 1917

8. AGE: Years	Months	Days	If less than one day
29	5	29	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Dursch
13. Birthplace S.C.

MOTHER
14. Maiden Name Sarah Trotty
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15 1946 (month) (day) (year)
(c) Cemetery or crematory Dumbarton
Location South Carolina

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St
(c) [illegible] (b) Huntington Williams M.D. (Registrar) Registrar

NOV 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13- 1946, at 2.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24- 1946 to 11-13- 1946 and that I last saw her alive on 11-13- 1946

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 3 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J H Bird M. D.
Address Balto City Hosps Date signed 11-13-46

VS Form

X

G15584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G15584

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 S. Monroe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Dabrasky

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George Dabrasky
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1854

8. AGE: Years 92 | Months 1 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Schneldy
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John F. Dabrasky
(b) Address 18 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Jorge L. Schwab
(b) Address 22 O.A. Frederick Avenue Huntington Williams, Md.

19 Date received NOV 16 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1946, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to Nov 14, 1946, and that I last saw h alive on Nov 13 19 46.

Immediate cause of death: Pulmonary Oedema — Duration 2 hrs
Due to: Bronchial Pneumonia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James H. Eisenberg M. D.
Address 724 Medical Arts Date signed 11/15/46

VS 180

X 1

G15585 BALTIMORE CITY HEALTH DEPARTMENT G15585
CERTIFICATE OF DEATH 94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Do not abbreviate. Use no ditto marks. If any item is unknown, write "unknown." Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Carroll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 V
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Carroll St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Potter Sr
3 (b) If veteran, name war —
3 (c) Social Security Account No. 705-06-6083

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bertha S. Potter
6 (c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) July 29. 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	3	16		

9. Birthplace Cumberland Md (Town, county, and state)
10. Usual Occupation Retired Brakeman
11. Industry or business B & O. R.R.

FATHER
12. Name Benjamin F. Potter
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. Conley
15. Birthplace Balto. Md

16 (a) Informant Bertha S. Potter
(b) Address 1101 Carroll St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18. 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave
18 (a) Funeral director Mrs. Mrs. John R. Gentle & Son
(b) Address 5311 Edmondson Ave
Huntington Williams, M.D. Registrar
NOV 16 1946
Vs 160 NOV 16 1946

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov 15 1946, at 8 20 a M
21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1946 to Nov 15 1946 and that I last saw him alive on Nov 15, 1946

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Arteriosclerosis	9 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Russell Schofield M.D.
Address 2301 Ampere Rd Date signed 11 15 46

G15586

CHK-104619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G15586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 25- 7
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Lancaster Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Gutowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9836

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15-1875

8. AGE: Years	Months	Days	If less than one day
71	5	29	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Prevel Gutowski
13. Birthplace Poland

MOTHER 14. Maiden Name Rosy ?
15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S. Conkling st

19 (a) Date received by Registrar 11 16 1946 (b) Signature for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1946, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1946 to Nov. 14 1946, and that I last saw him alive on Nov. 14 1946.

Immediate cause of death: Pulmonary Tuberculosis — duration unknown

Due to

Due to

Other Conditions Tbc enteritis — duration unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A.B. Hardy M. D.
Address Balto City Hosp Date signed 11-15-46

G15587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G15587

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 South Durham St
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 South Durham St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alexander Lewczak

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-18-6415

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Regina

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): ? 1882

8. AGE: Years: 64 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: Labor

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mrs. Regina Lewczak (Wife)
(b) Address: 726 South Durham Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-18-46 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Baltimore, Md.

18 (a) Funeral director: George A Weber
(b) Address: 705 South Ann Street

19 (a) NOV 16 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14th 1946, at 11.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 46, to Nov 14 19 46, and that I last saw him alive on Nov 14 1946.

Immediate cause of death: Coronary Occlusion — Duration: 9/13/46

Due to: Ch. Myocarditis — 8/1/45

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: William J Bauer M.D.
Address: 901 W Lombard St Date signed: 11/20/46

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45588 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45588 Registered No.

J.t.-AB

B.C.H. 461133 / 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20- 1946

8. AGE: Years	Months	Days	If less than one day
			hr. 45 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathaniel Boyd
13. Birthplace Florida

MOTHER
14. Maiden Name Lillian Hardy
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-26-1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 NOV 16 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20- 1946 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20- 1946 to 10-20- 1946 and that I last saw h 8F alive on 10-20- 1946

Immediate cause of death	Duration
Premature Birth	27 wks gestation
Due to Separation of Placenta	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin
Address Baltimore City Hospitals Date signed Oct 20 1946

VS 150

X

G45589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4230 Evans Chapel Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Evans Chapel Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ephraim Boring

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Georgia M. Boring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7-1865

8. AGE: Years 81 | Months 1 | Days 7 | If less than one day: hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual Occupation Plasterer
11. Industry or business Retired 26 years

FATHER
12. Name Mordicai C. Boring
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Burns
15. Birthplace Maryland

16 (a) Informant Miss Cora M. Boring
(b) Address 4230 Evans Chapel Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 1946 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Westminster, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3431 Falls Road Hunting Towson, Md.

19 (a) NOV 16 1946 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1946, at 1 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1944 to Nov 14 1946, and that I last saw h sons alive on Nov 13 1946.

Immediate cause of death: Myocardial failure — Duration 2 days
Due to: Arteriosclerotic Cardio-disease
Due to:
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Nov 16 Date signed Nov 15-46

VS 150

X

G15590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G15590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined before writing. Be sure to write the correct age in each case. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (13)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mildred E. Hilton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife Alfred Hilton
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-8-03

8. AGE: Years	Months	Days	If less than one day
43	3	7	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Walter Carlisle
13. Birthplace Va.
14. Maiden Name Desiree Elmsell
15. Birthplace Va.

16 (a) Informant Mrs Doris W Keeler
(b) Address 2708 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 16 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1946, at 2 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/1946 to 10/15 1946, and that I last saw h[illegible] alive on 11/15/1946.

Immediate cause of death respiratory failure

Due to Ca of pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of pelvis

of autopsy:

Duration over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Stevenson M. D.
Address St. Joseph's Hospital Date signed 11/16/46

X

VS 150

G15591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No. G15591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Biniasz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-41

8. AGE: Years	Months	Days	If less than one day
5	1	29	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Biniasz
13. Birthplace Md

MOTHER
14. Maiden Name Frances Stutowski
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 404 S. Chester Street

NOV 16 1946

19 (a) Date received by Registrar Lexington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1946 at 11:01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1946 to Nov. 15 1946 and that I last saw he alive on Nov. 15 1946.

Immediate cause of death — Duration

Tuberculous meningitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hubert Grayson M.D.
Address Johns Hopkins Hosp Date signed 11-15-46

X

VS 150

G45592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G45592

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 Carson Ct.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Carson Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Goins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16-1893

8. AGE: Years	Months	Days	If less than one day
53	3	28	hr. min.

9. Birthplace Marion Station Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia?
15. Birthplace Md.

16 (a) Informant Joseph Goins
(b) Address 1107 Carson Ct.

17 (a) Burial (b) Date thereof 11-18-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Saml. W. Chase & Son
(b) Address 638 N. Fulton Av.

19 (a) (Date of death) (b) Huntington Williams M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Nov. 13 1946, and that I last saw h[illegible] alive on Nov 13 1946.

Immediate cause of death	Duration
Cardio Vascular Renal Disease	1 yr.
Due to Uremia	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Schram Frey M. D.
Address 1908 Penna Ave. Date signed 11/20/46

G15593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No. G45593

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 E. Clement St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 E. Clement St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Bosley.

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. 220-01-4491.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Katie Bosley.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17-1878.

8. AGE: Years 68 | Months 7 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Day Watchman.

11. Industry or business

FATHER — 12. Name William Bosley.
13. Birthplace Md.

MOTHER — 14. Maiden Name Ella Hagney.
15. Birthplace Md.

16 (a) Informant Mrs. Katie Bosley.
(b) Address 527 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18-1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Charles J. Schulz.
(b) Address 505 N. Monroe St.

19 (Date received by local registrar) NOV 16 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14. 1946. at 11.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946, to Nov. 14 1946, and that I last saw h. alive on Nov. 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 hrs.
Due to Arteriosclerosis — 22
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Kohn
Address 1022 Fort Ave. Date signed 11/15/46

G45594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G45594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 N. Eden St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMANDA LITTLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife SAMUEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 10, 1894

8. AGE: Years	Months	Days	If less than one day
52 51	3	5	hr. min.

9. Birthplace YORK Co., VA.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name ALBERT DANNE
13. Birthplace VA.

MOTHER
14. Maiden Name JENNIE ?
15. Birthplace VA.

16 (a) Informant MARY COOK
(b) Address 610 N. EDEN ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Mrs. Robt. A. Elliott & Daughter
(b) Address 1129 N. Caroline St.

19 (a) NOV 16 1946 (b)
Registered by
Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1946 at 3a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Right cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 11/15/46

G45595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G45595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Abbott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Abbott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Senata Logan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Charlie Logan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1898

8. AGE: Years 48 | Months | Days | If less than one day: hr. min.

9. Birthplace Buckingham Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lacy Chambers
(b) Address 1627 Abbott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robt. A. Elliott Daughty
(b) Address 1129 N. Carlton St

19 (a) NOV 16 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1946 at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946 to 11-13 1946 and that I last saw her alive on 11-11 1946

Immediate cause of death: Pulmonary Embolism — Duration: 4 days

Due to Coronary Thrombosis — 3 wks.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 707 N. Caroline St. Date signed 11-14-46

VS 150

645596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 645596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 E. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Lurton Keys Reid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	Colored	Married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	18	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Th Lurton
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Netta
15. Birthplace Md.

16 (a) Informant James Reid
(b) Address 1004 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cemetery
Location U. A. County Md

18 (a) Funeral director Mrs. Robt. A. Elliott Dept
(b) Address 1129 N. Carlton

19 NOV 16 1946 (b) Registrar
(Date received by City Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1946, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2- 1946 to 11-13-1946 and that I last saw him alive on 11-11- 1946.

Immediate cause of death	Duration
Cardiac - Renal Disease	
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H Ranjel M. D.
Address 64 N. Carolina St Date signed 11-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 R

Registered No. G15597

PLEASE WRITE PLAINLY. WITH UNFADING INK. Entries must be made in permanent form or information should be carefully supplied. Use additional sheet if necessary. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1439 E. Eager St.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Young
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Gohue Young
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie ?
15. Birthplace Va.

16 (a) Informant Elizabeth Wright
(b) Address 1439 E. Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County Md

18 (a) Funeral director Mrs R. A. Elliott Dept
(b) Address 1129 N. Carlin St

NOV 16 1946 (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946, at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 12 1946 and that I last saw h[illegible] alive on Nov 12 1946

Immediate cause of death Oldage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Walters M. D.
Address 1443 E Eager Date signed 11/16/46

VS 150

G45598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G45598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and answered as correctly and completely as possible. Please write the causes of death clearly and legibly. Physicians: please be particular to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Eisler
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Eisler (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Marshall Dunagle

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife Raymond
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Manning S. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Fields
13. Birthplace S C

MOTHER
14. Maiden Name Mary Bronson
15. Birthplace S C

16 (a) Informant Minnie M. Knight
(b) Address 1116 Leadenhall

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Manning
Location S C.

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 408 W Montgomery St

19 (a) NOV 16 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1946 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1946 to 11/14/46 and that I last saw h alive on Nov. 13 1946.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to Chr. Cardiac-Hypertensive Disease	Unknown
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John W. Haines
Address 508 W. Hamburg St Date signed 11/15/46

VS 150

G15599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G15599 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Robertson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Peyton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911 – April 30

8. AGE: Years	Months	Days	If less than one day
35	6	15	hr. min.

9. Birthplace Jackson, N. C.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

MOTHER / FATHER
12. Name Matt Walker
13. Birthplace Va.
14. Maiden Name Mary Ramson
15. Birthplace Jackson, N C.

16 (a) Informant Mr. Peyton Robertson
(b) Address 1111 W. Lexington St.

17 (a) Burial, cremation, or removal
(b) Date thereof Nov. 17 (month) (day) 1946 (year)
(c) Cemetery or crematory Weldon
Location North Carolina.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

NOV 16 1946
(Date rec'd by registrar)
Katie R. Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15-1946 3.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14/1946 to 11/17/1946, and that I last saw her alive on 11/14/1946

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1 mo.
Due to: Tuberculosis — Duration: 1 mo.
Due to: " " — Duration:
Other Conditions: Cardiac Dilatation — Duration:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature W. Underdale M. D.
Address 5244 Cayuga Ave. 11/17/46

Please write plainly, with pen and ink. Physician: please write the cause of death clearly and legibly. Funeral director: please see that certificate is correct and complete before it is filed. Registrar: please see that certificate is correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G15600 — BALTIMORE CITY HEALTH DEPARTMENT — G15600

CERTIFICATE OF DEATH 170C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 W. mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Viola Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1881

8. AGE: Years 65 Months 10 Days 5 If less than one day hr. min.

9. Birthplace Henderson N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Benjamin Walker

13. Birthplace N.C.

MOTHER 14. Maiden Name Lucy Curtis

15. Birthplace Henderson N.C.

16 (a) Informant Mrs Dorothy Scott.

(b) Address 725 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

NOV 16 1946 (Date rec'd by registrar) (b) Huntingtor Williams, M

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1946, at 2 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck, Intracranial hemorrhage

Due to

Other Conditions Ruptured liver, spleen and kidney. Fract. ribs and long bones.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-9-46 2:15 A.M. M.

(b) Where did injury occur? Ordnance & East Sts

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Mueller M.D. Medical Examiner.

Date signed 11/9/46

VS 191

Kates

G15601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G15601

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns Sts
(c) Hospital or institution: Hospital for Women of Md 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Esther Genevieve Kates

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife David Kates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1872

8. AGE: Years	Months	Days	If less than one day
74	2	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name John Moylan
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Tuite
15. Birthplace Ireland

16 (a) Informant Dr Roy F Kates (Son)
(b) Address 2603 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave

19 (a) NOV 16 1946 (Date rec'd by registrar) (b) Hunting for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1946, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1946 to Nov 14 1946, and that I last saw h~~e~~r alive on Nov 14 1946.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Forrest H. Logan M. D.
Address Hosp for Women of Md Date signed 11/16/46

VS 3

X

G15602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 4514 G15602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 Bennington Road
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Bennington Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret A Plunkett
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6. (b) Name of husband or wife Frank J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16 1905

8. AGE: Years	Months	Days	If less than one day
41	6	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Frageser
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie Dawson
15. Birthplace Baltimore Md

16 (a) Informant Frank J. Plunkett
(b) Address 705 Benningham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road

18 (a) Funeral director John G Moran
(b) Address 3600 Baltimore St

19 Date rec'd by local reg. Nov 16 1946 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Nov 15 1946 and that I last saw her alive on Nov 14 1946

Immediate cause of death
(1) Carcinoma of the head primary
Due to (2) Migratory Phlebitis
Due to
Other Conditions Cardiac failure Anemia
(Include pregnancy within 3 months of death)

Duration
6 months

Date of operation
Major findings of operation (1) Carcinoma of the head (2) Primary
of autopsy: (3) Gall stones

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Manuel Sodaro M. D.
Address 4624 York Road Date signed Nov 15 46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15603

504589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

G15603
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted and correct as far as possible. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town Shelbyville (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 4. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Vaughan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-3-32

8. AGE: Years	Months	Days	If less than one day
14	2	13	hr. min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edgar Vaughan
13. Birthplace Ky.

MOTHER
14. Maiden Name Hazel Hibam
15. Birthplace Ohio

16 (a) Informant Parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/46 (month) (day) (year)
(c) Cemetery or crematory Graceland Cem. Shelbyville, Ky
(d) Location Shelbyville, Ky

18 (a) Funeral director John A. Mitchell & Son
(b) Address 1960 Eutaw Place

19 (a) (Date received by registrar) NOV 20 1946 (b) Registrar's signature Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1946, at 5.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1946, to Nov. 16 1946, and that I last saw him alive on Nov. 16 1946.

Immediate cause of death Pulmonary Hemorrhage — Duration 24

Due to Operation

Due to Fetal Congenital Heart disease — Duration Life

Other Conditions Simple ventricle Pulmonary Atresia Cyanosis (Include pregnancy within 3 months of death)

Date of operation 11/15/46

Major findings of operation: Pulmonary atresia

of autopsy: As above.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry T. Bahnson
Address Johns Hopkins Hospital Date signed 11/16/46

VS 150

G15601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G15601

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1244 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvina Catherine E Morton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Howard L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1900

8. AGE: Years 36 | Months 1 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER 12. Name Bernard Espey

13. Birthplace Germany

MOTHER 14. Maiden Name Marie Sekus

15. Birthplace Germany

16 (a) Informant Mr Howard L Morton

(b) Address 1244 Washington Blvd

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location 3800 Frederick Rd

18 (a) Funeral director John J. Fouraker & Son

(b) Address 901-07 Hollins St.

19 (a) [illegible] (b) Huntington Williamsport

NOV 16 1946

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15th 1946, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 19 46 to 11/15 19 46 and that I last saw her alive on 11/15 1946.

Immediate cause of death Carcinoma of left breast — Duration 3 mos.

Due to

Due to

Other Conditions Metastatic cause of Left breast — Duration 2 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller

Address 20 30 Wilkens Ave Date signed 11/20/46

X

G15605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

89B

Registered No. G15605

write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Eye Ear Nose & Throat Hospital
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Aborn
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Allegheny
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Springdale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bonnie J. Rinker.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed or divorced~~:
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 29 June 1944

8. AGE: Years	Months	Days	If less than one day
2	4	17/30	hr. min.

9. Birthplace Cumberland Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Charles Ralph Rinker
13. Birthplace Cumberland, Md

MOTHER
14. Maiden Name Mattie Elizabeth Keefer
15. Birthplace Fulton County, Penn.

16 (a) Informant Father
(b) Address 222 Springdale St. Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 16 Nov. 46 (month) (day) (year)
(c) Cemetery or crematory Cumberland
Location Cumberland Md

18 (a) Funeral director F. D. Shippert & Son
(b) Address 130 Eutaw Place

NOV 16 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Nov 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov 1946 to 19 , and that I last saw h alive on 15 Nov 1946,

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchial pneumonia	18 hrs
Due to	
Other Conditions Chronic mastoiditis, left, Cong. Spastic paraplegia (Include pregnancy within 3 months of death)	
Date of operation 14 Nov 1946	
Major findings of operation: Chronic infection, left mastoid	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frederick K. Griff M.D.
Address 1814 Eutaw Place Date signed 16 Nov. 46

V2 3

G15606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2140 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Annie Glasel (ANNIE GLASEL)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Leopold Glasel
6 (c) If married, widowed, or divorced, give age last birthday years
7. Birth date of deceased (mo., day, yr.) Sept 4 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	2			

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Gabriel Langfelder
13. Birthplace Austria

MOTHER 14. Maiden Name Rosalia Lang Austria
15. Birthplace

16 (a) Informant Adolph Langfelder
(b) Address 2140 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-46 (month) (day) (year)
(c) Cemetery or crematory Hungarian Jewish Union Hill Cypress Grove (Baltimore)
Location

18 (a) Funeral director J. AHRENS & SON
(b) Address Funeral Directors

19 (a) Registered (Date received by registrar) 11-19-1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 - 1946, at 3:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1946 to Nov 16 1946, and that I last saw h[illegible] alive on Nov 15 1946.

Immediate cause of death Pneumonia — Duration

Due to Bronchopneumonia

Due to

Other Conditions Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 11/16/46

VS 150

Hunting for Missing

107

G15607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 186a

G15607
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CATON & WILKENS AVE
(c) Hospital or institution:
ST. AGNES
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town CATONSVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 NEWBURG AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. LUCY PALMER

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: THOMAS ALFRED PALMER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 9, 1865

8. AGE: Years 81 | Months 6 | Days 7 | If less than one day ___ hr. ___ min.

9. Birthplace VIRGINIA
(town, county, and state)

10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name RICHARD MILLER
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name SARAH ?
15. Birthplace VIRGINIA

16 (a) Informant HUGH S. PALMER
(b) Address WASHINGTON D.C.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory HOLLYWOOD CEM.
Location RICHMOND VA.

18 (a) Funeral director Easton, Howard
(b) Address Catonsville Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, Registrar

NOV 19 1946

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1946, at 10:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/12 1946 to 11/16 1946, and that I last saw h[er] alive on 11/16 1946.

Immediate cause of death	Duration
(a) Cardiac failure due to Cardiac Fibrosis arteriosclerosis - fracture	
Due to (b) (1 week) Rt femur	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11/12/46 at M
(c) Where did injury occur? 700 Newburg Ave
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fall striking to floor

23. Signature D. W. Miller M. D.
Address St Agnes. Date signed 11/16/46

Howard D. Chappelear, M.D.

G45608 G45608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 E. Lake Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12, (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 E. Lake Avenue. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George Rufus Nelson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith May Nelson
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 2, 1870

8. AGE: Years	Months	Days	If less than one day
76	8	14	9 hr. 50 min.

9. Birthplace Crisfield, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Nelson
13. Birthplace Maryland

MOTHER
14. Maiden Name Henrietta Sterling
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address 220 E. Lake Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/19/46 (month) (day) (year)
(c) Cemetery or crematory Asbury M. E. Church
Location Crisfield Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 17 1946
VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1946, at 9:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1945, to Nov. 15, 1946, and that I last saw him alive on Nov. 15 1946.

Immediate cause of death Chronic Myocarditis — Duration 1 Mo.
Due to
Due to
Other Conditions Cirrhosis of Liver (Include pregnancy within 3 months of death)
Major findings:
Of operation Cirrhosis of Liver
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 914 York Road Date signed 11-15-46

X

G45609 BALTIMORE CITY HEALTH DEPARTMENT G45609

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3314 N North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3314 N North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Le Cron

3 (b) If veteran, name war no
3 (c) Social Security Account No. none

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 30 1871

8. AGE: Years 75 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation housework
11. Industry or business

FATHER
12. Name James Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann McCall
15. Birthplace Ireland

16 (a) Informant Margaret LeCron Conachy
(b) Address 909 N. Wanamaker Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Milton A Lee
(b) Address 1217 E Fort Ave

19 (a) 1946 (date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1946, at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1945 to Nov 16 1946 and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion — Duration 1 hr

Due to: advanced arteriosclerosis & hypertension — Duration ? about 9 mo.

Due to:

Other Conditions: Coronary disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was ~~due to external causes~~, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury ~~occur~~ about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hallie Dabbot M. D.
Address Date signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

conflict age is especially important. Physicians: please write the causes of death clearly and legibly.

G45610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G45610 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland
(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towsontown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9142 Du Bois Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel N Knighton

3 (b) If veteran, name war: W

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1877

8. AGE: Years	Months	Days	If less than one day
69	8	13	hr. min.

9. Birthplace Baltimore Md
(town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John T Knighton
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Margaret A Lentz
15. Birthplace Baltimore Md

16 (a) Informant Katherine Smith
(b) Address 104 Du Bois Ave Towsontown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1317 E Pratt St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1946 to 11-15 1946 and that I last saw him alive on 11-15 1946.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Bedwany M.D.
Address West Balto Dent'l Hosp Date signed 11/16/46

VS 150

G45611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G45611 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) About 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. North Ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Anna Babette Doelleumer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1871

8. AGE: Years	Months	Days	If less than one day
75	2	14	hr. min.

9. Birthplace Bavaria, Germany (Town, county, and state)
10. Usual Occupation Confectioner
11. Industry or business Baking

FATHER
12. Name Christian Doelleumer
13. Birthplace Hamburg, Germany

MOTHER
14. Maiden Name Johanna Pittroff
15. Birthplace Bavaria, Germany

16 (a) Informant Mrs Emma D Hughes
(b) Address 29 E North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Baltimore Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 802 N. Calvert St.

NOV 17 1946 (a) (Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1946, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1946, to November 15 1946, and that I last saw h[illegible] alive on Nov 15 1946.

Immediate cause of death Cerebral Vascular accident — Duration 2 days

Due to Arteriosclerosis hypertension — Duration ? 8 years

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation? —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W Gluck M. D.
Address 715 Park Ave Date signed 11/20/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15612 G15612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Powhattan Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Powhattan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Caplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Joseph Sachs
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Glass
15. Birthplace Russia

16 (c) Informant Paul Caplan
(b) Address 3400 Powhattan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1946 (month) (day) (year)
(c) Cemetery or crematory Jachew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received Nov 17 1946 (b) Registrar's signature [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1946, at 2:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1946, to Nov. 17 1946, and that I last saw h[illegible] alive on Nov. 17 1946

Immediate cause of death	Duration
Pulmonary Oedema	1 day
Due to Uremia	1 week
Due to Hypertension; Chronic nephritis	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Gibbs M. D.
Address Temple Gardens Apt Date signed 11/17/46

VS 150

X

G15613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G15613
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 330 Maude Ave - Zone 25
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 25 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 Maude Ave - 25
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Voelker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband John Voelker (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22-1884

8. AGE: Years 62 | Months 1 - | Days 22 - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Louis Ott
13. Birthplace Balto. - Md

MOTHER
14. Maiden Name Acalia Parker
15. Birthplace Balto. Md

16 (a) Informant Mr John Voelker
(b) Address 330 Maude Ave - 25 -

17 (a) Burial (b) Date thereof Nov 18-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Cedar Hill
Location Gor. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St.

19 (a) Date received Nov 17 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Nov 1946, and that I last saw h[illegible] alive on Nov 14 1946.

Immediate cause of death Coronary occlusion — Duration

Due to hypertension cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. W. Lister, MD
Address 302 Patapsco Ave Date signed 11 M. 17 D. 46.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15611 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 46 B — Registered No. G15611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1640 Preston Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Isaac Silesky

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife. Mrs Isaac Silesky

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1865

8. AGE: Years 81 | Months 2 | Days 4 | If less than one day 7 hr. 40 min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation ? Artist

11. Industry or business

FATHER
12. Name Benjamin Silisky
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Yackson
15. Birthplace Russia

16 (a) Informant Mrs Isaac Silesky
(b) Address 1640 Preston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jacob Lewis & Sons
(b) Address 1469 E Baltimore St

NOV 17 1946 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16- 1946, at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1946 to Nov 16 1946 and that I last saw him alive on Nov 15 1946

Immediate cause of death: Ca of the stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George G. Gallinger

Address U. of M. Date signed 11/14/46 (M. D.)

VS 150

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G15615 — BALTIMORE CITY HEALTH DEPARTMENT — G15615 Registered No.

CERTIFICATE OF DEATH 113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 S. High St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Vittoria Monaco

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Savino Monaco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 25 1884

8. AGE: Years 62 Months 1 Days 21 If less than one day hr. min.

9. Birthplace: Rodi Foggia Italy (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Tommaso Carnevale
13. Birthplace: Italy

MOTHER
14. Maiden Name: Filomena Del Conte
15. Birthplace: Italy

16 (a) Informant: Savino Monaco (Husband)
(b) Address: 115 S. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18 1946 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Belair Rd. Baltimore Md.

18 (a) Funeral director: Frank Della Vecchia
(b) Address: 52 N. Morley St.

19 (a) 11 17 1946 (Date received by registrar) (b) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1946, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7, 1946 to Nov. 15, 1946, and that I last saw her alive on Nov. 15, 1946.

Immediate cause of death	Duration
Pulmonary Hemorrhage	15 min.
Due to Tuberculosis	1 year
Diabetes Mellitus	Unknown
Due to: Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Philibert Artigiani M. D.
Address: 2942 E. Fayette St. Date signed 11/16/46

X

G45616 BALTIMORE CITY HEALTH DEPARTMENT G45616

CERTIFICATE OF DEATH 46a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address U. S.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorner, John Joseph
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Wh
6 (a) Single, married, widowed, or divorced wid
6 (b) Name of husband or wife Julia Sema
6 (c) If alive, give age 4 years
7. Birth date of deceased (mo., day, yr.) 9/2/87
8. AGE: Years 59 Months 2 Days 15 If less than one day hr. min.
9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Roadwork
11. Industry or business

FATHER
12. Name Frank Dorner
13. Birthplace Hungary

MOTHER
14. Maiden Name Anna Locken
15. Birthplace Hungary

16 (a) Informant Records - U. S. Marine Hosp.
(b) Address Balto., Md.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory St. Nicholas Cem.
Location Lodi New Jersey
18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.
19 (a) Registrar Huntington Williams, M.D.

NOV 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1946, at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1946, to Nov. 17 1946, and that I last saw h im alive on Nov. 16, 1946.

Immediate cause of death: Carcinoma esophagus - duration — Duration: 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 3, 1946

Major findings of operation: Carcinoma esophagus

of autopsy: not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willys M. Monroe
Address U.S. Marine Hospital Date signed 11.17.46 M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15617 BALTIMORE CITY HEALTH DEPARTMENT G15617
CERTIFICATE OF DEATH 186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (~~years~~ days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 South Payson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C Rodeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 · 7 · 1877

8. AGE: Years 69 | Months 8 | Days 8 10 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name John R. Reed
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Pensonetto
15. Birthplace Baltimore

16 (a) Informant Mrs. Herbert Rodeman
(b) Address 12 South Payson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros
(b) Address 1217 W Fayette St

19 (a) (Date rec'd by registrar) Hunting Ton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 17 1946, at 4 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 · 22 1946 to 11 - 17 1946, and that I last saw h alive on 11 - 17 1946.

Immediate cause of death: Heart failure — Duration

Due to Congestion from pulmonary embolism

Due to Embolism coming from site of fracture femur

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/3
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence 10 - 22 - 46 at 8 22 P.M
(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell down stairs at home fracture femur

23. Signature Richard G. Mallon
Address Maryland Gen. Hosp. Date signed 11-17-46 M. D.

VS 180

For Dr. C. J. Sabinski, by Howard J. Mallon, M.D.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

45618

TH 105354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G45618

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 9 W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 N. 30th St (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country England

3 (a) FULL NAME Emily Salt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Salt (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23/1862

8. AGE: Years	Months	Days	If less than one day
84	3	22	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name ? ? ?
13. Birthplace England

MOTHER
14. Maiden Name Helen Moore
15. Birthplace England

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 127 St. Paul St.

NOV 18 1946 Washington Hill (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15/1946 19 at 11:P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17/ 1946 to Nov. 15 1946 and that I last saw her alive on Nov. 15 1946

Immediate cause of death: Asthenogastenic Cardio-Vascular Disease with Bronchial thrombosis — Duration

Due to

Other Conditions Intertrochanteric fracture - left femur

(Include pregnancy within 3 months of death)

Date of operation 10-21-46

Major findings of operation: Same.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10-15-46 at M
(c) Where did injury occur? Baltimore (City or town) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Tripped & fell on left hip.

23. Signature Marvin M. Lazy, M.D.
Address Baltimore City Hosp. Date signed 11-16-46

Dr. J. Lubenthal
Hombil & Clendenin, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15619 B.C.H.-62059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161 C

Registered No. G15619

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 S Gough St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Diana Mary Rockl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 16 1946

8. AGE: Years	Months	Days	If less than one day
			6 hr. 20 min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Albert Rockl
13. Birthplace Baloch Wis

MOTHER
14. Maiden Name Bertha Amelia Grochowski
15. Birthplace Balto Md

16 (a) Informant Father
(b) Address 210 S Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balto. City

18 (a) Funeral director John Jr. Weber
(b) Address 481 S. Chester street

NOV 18 1946 (Date rec'd by local reg.) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Nov 1946, at 9 15 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Nov 1946 to 16 Nov 1946 and that I last saw h ER alive on 16 Nov 1946.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Erythroblastosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Biopsy of liver taken

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry T. Wilson, Jr
Address St. Joseph's Hospo Date signed 16 Nov 46

VS 150

15628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

G15628D

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution: The Seton Institute

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1-17

(e) Length of stay in Baltimore (yrs., mos., or days) 3-1-17

2. USUAL RESIDENCE OF DECEASED:

(a) State Pennsylvania County

(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)

(d) Street No. 3667 Mt Vale Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Helen Mc Gunyon

3 (b) If veteran, name war

3 (c) ~~Social Security~~ Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-1-1864

8. AGE: Years	Months	Days	If less than one day
82	3	16	hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER — 12. Name David J. McGunyon

13. Birthplace Philadelphia Pa.

MOTHER — 14. Maiden Name Ellen O'Hara

15. Birthplace Philadelphia

16 (a) Informant The Seton Institute

(b) Address 6420 Reisterstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-18-46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Delaware Co - Pa

18 (a) Funeral director Stewart Mortuary,

(b) Address 108 Winstead.

NOV 18 1946 (Date received by Local Registrar) Huntington Williams M.D. (Signature of Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1946 to Oct 16 1946, and that I last saw her alive on Oct 16 1946.

Immediate cause of death: Myocardial Infarct — Duration 1 mo.

Due to

Due to

Other Conditions Psychosis with arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 536 Pittsfield Bldg. (Signed)

VS 150

P.C. D-62029

G41562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157c

G41562 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 N. Curley St #
(c) Hospital or institution: Franklin Sq. Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Curley St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl McGlynn.
3 (b) If veteran, name war —
(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1946

8. AGE: Years	Months	Days	If less than one day
			22 hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Hugh McGlynn
13. Birthplace 19 N. Curley St.

MOTHER
14. Maiden Name Betty McGlynn
15. Birthplace 19 N. Curley St.

16 (a) Informant Mr. Hugh McGlynn
(b) Address 19 N. Curley St.

17 (a) Burial (b) Date thereof Nov 18 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity Cem.
Location Edmund St.

18 (a) Funeral director F. V. Altstine
(b) Address 268 E. Balto St.

19 (a) NOV 18 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946, to Nov. 16 1946, and that I last saw h live on Nov. 16 1946

Immediate cause of death Anencephalia — Duration 1 day

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. N. Williams M. D.
Address Franklin Sq. Hosp. Date signed 17 Nov. 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15628 G15628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G15628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 6.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 W. Elm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa C. Murkey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Louis. E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/1897

8. AGE: Years	Months	Days	If less than one day
49	4	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Wagner
13. Birthplace Md

MOTHER
14. Maiden Name Emma ?
15. Birthplace Md.

16 (a) Informant Louis E. Murkey
(b) Address 31 W. Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-46 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Baltimore Md.

18 (a) Funeral director F. J. Reuss.
(b) Address 53 S. Stanford Rd

19 (a) (b) Huntington Williams, M.D.
(Undertaker or person acting as such)

NOV 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16-46 19 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6-46 19 to 11-16-46 19 and that I last saw her alive on 11-16-46

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Meningo-Encephalitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Wilson M. D.
Address St. Joseph's Hosp Date signed 16 Nov 46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G45623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. G45623

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Leon Susskins
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Lee
15. Birthplace Russia

16 (a) Informant Leon Miller
(b) Address 3708 Clarks Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-46 19 at 3:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to 11-17 1946, and that I last saw him alive on 11-12 1946.

Immediate cause of death: Bronchio pneumonia — Duration 10 days

Due to

Due to

Other Conditions Hypertension - Cardiac Hypertrophy - Cardiac Insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Cooper M. D.
Address 2201 Eutaw Place Date signed 11/17/46

G156234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1316

Registered No. G156234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 Ramsay ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 Ramsay ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph L. Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Pete Helen E Dennison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10 1868

8. AGE: Years	Months	Days	If less than one day
78	3	6	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Charles H Shipley
13. Birthplace Md

MOTHER 14. Maiden Name Rebecca J.
15. Birthplace Md

16 (a) Informant Mrs Mary Little
(b) Address 1529 Ramsay St

17 (a) Burial (b) Date thereof Nov 18 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3301 Freedom Rd.

18 (a) Funeral director Harry H Wetzler
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 18 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1946, at 74 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1946, to Nov 16 1946, and that I last saw him alive on Nov 15 1946.

Immediate cause of death	Duration
(a) Chronic Nephritis	
Due to	
Due to	
Other Conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Seagrotta M. D.
Address 1724 W Lombard St Date signed 11/16/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15625 G15625

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 Brunt St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcellus Estep

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Neaton Estep
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1887

8. AGE: Years	Months	Days	If less than one day
59	1	2	hr. min.

9. Birthplace Charles Co Md (Town, county, and state)
10. Usual Occupation Driver
11. Industry or business

FATHER
12. Name Robert Estep
13. Birthplace Charles Co Md

MOTHER
14. Maiden Name Sidney Toye
15. Birthplace Charles Co Md

16 (a) Informant Neaton Estep
(b) Address 726 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-46 (month) (day) (year)
(c) Cemetery or crematory Charles Co Md
Location md
18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave
19 (a) (Signature) (Address)

NOV 18 1946

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1946 at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1946 to 11-15 1946 and that I last saw h[illegible] alive on 11-14 1946

Immediate cause of death Hypertension Cardio Vascular Renal Disease — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Atwell Jones M.D.
Address 554 Dolphin St Date signed 11-15-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G156260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. G156260

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 N. Washington St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Krause

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida Krause
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) June 12, 1869

8. AGE: Years	Months	Days	If less than one day
77	5	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation General laborer
11. Industry or business McShane Bell Foundry

FATHER
12. Name Krause
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. Ida Krause
(b) Address 1719 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 NOV 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1946 19 . at 8 P/M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Nov. 15 1946.
and that I last saw h[illegible] alive on Nov. 15 1946.

Immediate cause of death Carcinoma of Liver. Duration
a Diseased

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ida Krause M.D.
Address 11 E Chase St Date signed 11/17/46

G45627

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164B

G45627 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Venable Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LYDIA ELIZABETH WOLF

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Louis G. Wolf
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 29, 1882
8. AGE: Years 63 Months 10 Days 17 If less than one day hr. min
9. Birthplace: Crisfield, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown - Ford
13. Birthplace: Unknown

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Marie Owens
(b) Address: 812 E. 35th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

NOV 18 1946

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1946, at 1.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning
Due to
Other Conditions Arteriosclerotic cardio-vascular-renal disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-46 at ? M.
(b) Where did injury occur? Montebello Lake
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Jumped into lake.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11-15-46

X

G4562 8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G4562 8

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 E. Montgomery St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 E. Montgomery St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Joseph Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gladys Gordon

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) April 24 1902

8. AGE: Years	Months	Days	If less than one day
44 45	6	21	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Stationery Engineer

11. Industry or business

FATHER 12. Name John Thomas Gordon

13. Birthplace Md.

MOTHER 14. Maiden Name Theresa F. Milske

15. Birthplace Md.

16 (a) Informant Mrs Gladys Gordon

(b) Address 1 E. Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director John F Kenny Inc

(b) Address 745 Light St.

19 (a) [illegible] Washington, N[illegible]

NOV 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1946, at 7 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 5, 1944 to NOV. 15 1946 and that I last saw [illegible] alive on SEPT 21 1946.

Immediate cause of death ANGINA PECTORIS — Duration 2 1/2 YRS

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE — UNKNOWN

Due to

Other Conditions CHR. CHOLECYSTITIS — UNKNOWN

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Weisel

Address 1226 HANOVER ST. Date signed 11/16/46

Howard J. Weisel, M. D.

G15629

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

G15629
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital 2074 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Virginia
(town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant James Wright
(b) Address 22 N Bond St

17 (a) Burial (b) Date thereof 11-18-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary A. A. Co
Location

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) NOV 18 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1946, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Due to inhalation of Smoke.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov 15 1946 at 12:30 P.M.
(b) Where did injury occur? 22 N Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Room caught on fire

23. Signature William F Reed M.D.
Medical Examiner.
Date signed Nov 15, 1946

VS 181

G45630 — G4560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada Bonsner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-04

8. AGE: Years	Months	Days	If less than one day
42	6	22	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Elsey

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Adie Hilla

MOTHER 15. Birthplace Md

16 (a) Informant Richards

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem. Location B. A. County, Md.

18 (a) Funeral director Joseph B. Forbs, Jr.

(b) Address 1530 E. Central Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946 at 10:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1946 to Nov. 13 1946, and that I last saw her alive on Nov. 13 1946.

Immediate cause of death: Cardiac failure — Duration: 5 years

Due to Hypertension C.V. disease & cardiac enlargement auricular

Due to fibroid of uterus (submucous) — 3 mos

Other Conditions Cerebral embolism, left cerebral hemisphere

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. J. Davis M. D.

Address Johns Hopkins Hospital Date signed 11/3/46

Hunterington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

41595D

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122 B

G41563 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Dolphin St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Chambers Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-12-62

8. AGE: Years	Months	Days	If less than one day
84	4	2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Lamb Edlin
13. Birthplace Md.
MOTHER 14. Maiden Name Jane Newton
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Westport, Balto. Md.
18 (a) Funeral director John McDonough
(b) Address 1700 Druid Hill Ave.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1946 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1946 to Nov 14 1946 and that I last saw him alive on Nov 14 1946

Immediate cause of death: Cardiac Failure & Auricular Fibrillation — Duration: Acute
Due to Operation for — 1 d.
Due to Volvulus of Sigmoid — 4 d.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11-12-46
Major findings of operation: Volvulus of Sigmoid & gangrene
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. B. Morrow M. D.
Address USPH Date signed 11-15-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

B.L. 9-61935

G45632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G45632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilson & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Lake Rd. - Riviera Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Young
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1946

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edmund Young
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ernestine Flannery
15. Birthplace Ky.

16 (a) Informant Edmond Young
(b) Address Riviera Beach Pasadena P.O. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18 46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Langston
(b) Address Glen Burnie, Md.

19 (a) NOV 18 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1946 at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1946 to 11-16 1946, and that I last saw h/ alive on 11-16 1946.

Immediate cause of death Hydrocephalus
Rachischisis

Due to Ingestion of malformation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Thos. J. Peak M.D. M. D.
Address St. Agnes Hospital. Date signed

Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G15633 BALTIMORE CITY HEALTH DEPARTMENT 13B Reg. No. G15633.

CERTIFICATE OF DEATH

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 JACK ST.
(c) Hospital or institution:

25-14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMURE, MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 JACK ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MYRTLE VIOLA WAGELEY

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	MARRIED

6 (b) Name of husband or wife ARTHUR THOMAS WAGELEY
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 9/3/96

8. AGE: Years	Months	Days	If less than one day
50	2	14	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business "

FATHER
12. Name HENRY MORSBERGER
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name — BALDWIN
15. Birthplace BALTIMORE, MD.

16 (a) Informant ARTHUR THOMAS WAGELEY
(b) Address 400 JACK ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory LOUDIN PARK
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 NOV 18 1946 (Date received by registrar) Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 17, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1945 to 11/17/1946, and that I last saw h[illegible] alive on 11/17/46

Immediate cause of death
Pulmonary Tuberculosis — Duration 13 mos.
Due to —
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence D. Leon M.D.
Address 11 E. Chase St. Date signed 11/18/46

Huntington Hospital, Huntington, W. Va.

X

G45633 | BALTIMORE CITY HEALTH DEPARTMENT | G45633

CERTIFICATE OF DEATH 1937

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Myrtle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josiah Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	married

6 (b) Name of husband or wife Annie Baker.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1875

8. AGE: Years	Months	Days	If less than one day
71 69	6	27	hr. min.

9. Birthplace A. A. County Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Baker.
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden Name Turner.
15. Birthplace A. A. Co. Md.

16 (a) Informant Mrs. Annie Baker.
(b) Address 1316 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Wm. Katie R. Williams
(b) Address 822 W. Lexington St.

19 (a) NOV 18 1946 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1946, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Nov. 1946 and that I last saw him alive on Nov. 15 1946

Immediate cause of death

	Duration
Hypertensive Cardio-Vascular Disease	Years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ford A. Wills
Address 825 E. 41st St. Date signed 11/17/46

VS 150

Huntington Williams, M.D.

X

Correct age if especially important. Physician: please write and

215635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

Registered No. C25[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Overland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Basto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Overland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marian V.

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 10 1875

8. AGE: Years	Months	Days	If less than one day
71	6	6	hr. min.

9. Birthplace Basto.
(Town, county, and state)

10. Usual Occupation automobile accessories

11. Industry or business self

FATHER
12. Name Conrad Fischer
13. Birthplace Basto.

MOTHER
14. Maiden Name Regina Long
15. Birthplace Basto.

16 (a) Informant Marian V. Fischer
(b) Address 2901 Overland Ave

17 (a) Burial (b) Date thereof 11/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director H. W. E. Dapp & Son
(b) Address 7110 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Hill, Md.

NOV 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1946 at 8:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943 to Nov. 16 1946 and that I last saw h[illegible] alive on Nov. 16 1946

Immediate cause of death	Duration
coronary thrombosis	3 years
Due to generalized arteriosclerosis	[illegible]
Due to senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William C. Dunnigan M. D.
Address 31 E North Ave Date signed 11/17/46

X

G1563b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G1563b Registered No.

Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 Waldo st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Waldo st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Verdella Scott Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-1887

8. AGE: Years	Months	Days	If less than one day
59	109	16th	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Benjamin Ross
13. Birthplace Maryland.

MOTHER
14. Maiden Name Harriett Frances
15. Birthplace Maryland.

16 (a) Informant Elsie Young
(b) Address 716 N Caroline st

17 (a) Burial (b) Date thereof 11-19-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary.
Location Baltimore, Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson st

19 (a) (Date received by registrar) (b) Registrar

NOV 18 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1946, at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1945 to 11/16 1946 and that I last saw her alive on 11/16 1946

Immediate cause of death: hypertensive cardio-renal disease — Duration: 2 years

Due to (cardiac failure)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Brownell X

Address 1 SW E. Madison st Date signed 11/17/46 M. D.

Rayner Brownell X

G15636 — BALTIMORE CITY HEALTH DEPARTMENT — G15636 Registered No.

CERTIFICATE OF DEATH

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond Pk. Ave
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 1124 E. 20th St.
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country * * *

3 (a) FULL NAME GEORGE RAUSCH

3 (b) If veteran, name war	3 (c) Social Security Account No.	MEDICAL CERTIFICATION
No	218-05-6244	20. DATE OF DEATH Nov. 16 1946 at 7 P M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillian E. Rausch
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 24 1890

8. AGE Years	Months	Days	If less than one day
56	7	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman Baker Bus.
11. Industry or business

FATHER
12. Name Frederick Rausch
13. Birthplace Germany

MOTHER
14. Maiden Name Annette Huer
15. Birthplace Baltimore

16 (a) Informant Lillian E. Rausch
(b) Address 1124 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Edmonson Ave.

18 (a) Funeral director Charles F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 18 1946

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1946 to Nov. 16 1946, and that I last saw [illegible] alive on Nov. 16 1946.

Immediate cause of death Respiratory failure — Duration

Due to Cerebro vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Holmes M. D.
Address Univ. Hosp. Date signed 11/18/46

G45638 — BALTIMORE CITY HEALTH DEPARTMENT — G45638 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Calvert st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY MORRIS

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 212-18-0810

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18 1899

8. AGE: Years	Months	Days	If less than one day
47	9	24	hr. min.

9. Birthplace Frostburg Md.
(City, county, and state)
10. Usual Occupation Johns Hopkins Hosp
11. Industry or business

FATHER
12. Name Edward Morris
13. Birthplace Frostburg Md.

MOTHER
14. Maiden Name Annie Powers
15. Birthplace Frostburg Md.

16 (a) Informant Agnes Iaquinto
(b) Address 212 N. Greene St.

17 (a) Burial (b) Date thereof Nov. 20 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 3911 Liberty Hghts Ave.

NOV 18 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12th 1946, at 7:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner
Date signed 11/12/46

VS 181

G45639 BALTIMORE CITY HEALTH DEPARTMENT 134 G45639
335a Registered No. (WA)

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Warner St. Balto 30, Md
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Warner St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mark Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-5477

4. Sex male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Etha Bryant

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 12/31/1891

8. AGE: Years 54 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER
12. Name Samuel Bryant
13. Birthplace Va.
14. Maiden Name Lucy Wells
15. Birthplace Va.

16 (a) Informant Etha Bryant
(b) Address 605 Warner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah L. Brinkley
(b) Address 1084 W Montgomery St

19 (a) NOV 10 1946 (Date received by registrar) (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/1946 at 4:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1946 to Nov. 5 1946 and that I last saw h[illegible] alive on Oct. 14 1946

Immediate cause of death

	Duration
(a) Lobar Bronchopneumonia	15 days
Due to (b) Influenza	3 days
Due to (c)	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lincoln Sheldon M. D.
Address 908 S. Wolfe St. Date signed 11/8/46

VS 150

380576 G15624D

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G15695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town Columbia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Harden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Coke Gray
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Virginia A. Gray
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 3-1-88

8. AGE: Years	Months	Days	If less than one day
58	8	17	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation auto dealer
11. Industry or business

FATHER
12. Name Wm Li Gray
13. Birthplace S.C.

MOTHER
14. Maiden Name Laurel Dill
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory Laurens Cemy.
Location Laurens, S.C.
18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place
19 (a) NOV 18 1946 (Signature of registrar) Virginia [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1946, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10- 1946 to 11-18- 1946, and that I last saw h alive on 11-18- 1946.

Immediate cause of death

	Duration
Due to hypernephroma left; renal abstraction at + secondary clots	3 wks
Due to intraperitoneal adhesions; partial fistula; ventral segment resection	10 days
Other Conditions Carcinoma Bladder & Ureters - Left Kidney	2 mos

(Include pregnancy within 3 months of death)
Date of operation 7-12-46
Major findings of operation: Ca of bladder
of autopsy: satisfact. Nephrectomy; Ca of bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Willard E. Goodwin
Address J. H. H. Date signed 11/18/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G15619 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harlington & Linden
(c) Hospital or institution: Md. Gen. Hosp. 5 mo.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 N. Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Edna M. Ballman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1877

8. AGE: Years	Months	Days	If less than one day
69 68	1	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name August F. Ballman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Clara Jackson
15. Birthplace Balto. Md.

16 (a) Informant Mrs. H. T. Mims
(b) Address 120 Ruskin Ave., Pittsburg, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 19 (day) 46 (year)
(c) Cemetery ~~or crematory~~ London Park
Location 3801 Frederick Ave.

18 (a) Funeral director John J. Mitchell & Son, Inc.
(b) Address 1900 Eaton Place

19 (a) (Date rec'd by registrar) NOV 18 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-46 19 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8-46 19 to 11-17-1946 and that I last saw her alive on 11-16-46 19

Immediate cause of death	Duration
Carcinoma Cervix	
Due to Carcinoma Cervix with metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas C. Webster M. D.
Address Md. Gen. Hosp. Date signed 11-17-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15612 BCH 9867/37 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH V 1190 G15612 Registered No.

please write the causes of death clearly and legibly. Physicians: please state correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 6702 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Donnie Suzanne Dieter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/29/45

8. AGE: Years	Months	Days	If less than one day
	11	15	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

MOTHER / FATHER
12. Name John N. Dieter
13. Birthplace Balto Md.
14. Maiden Name Clarence Cook
15. Birthplace Balto Md.

16 (a) Informant J. N. Dieter
(b) Address 6702 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/46 (month) (day) (year)
(c) Cemetery or crematory Lebenwater
Location Balto Md

18 (a) Funeral director Loggabstonal Home
(b) Address 7401 Belair Rd

19 (a) Filed (Date received by registrar) NOV 18 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17/ 1946, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17/ 1946 to 11/17/ 1946, and that I last saw h[illegible] alive on 11/17/ 1946.

Immediate cause of death	Duration
Acidosis	
Due to Dehydration	10 minutes
Due to Vomiting and Diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. C. Gonzales M. D.
Address Maryland G. Hospital Date signed
Dr. John R. Owens
Dr. Howard J. Andersen, M.D.

G15613 BALTIMORE CITY HEALTH DEPARTMENT G15613
CERTIFICATE OF DEATH 1937 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3449 Hickory Ave (If no No., give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith C. Strickland

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: James R. Strickland
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 2nd 1877
8. AGE: Years 69 Months 9 Days 27 If less than one day hr. min.
9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Edith Allen
15. Birthplace unknown

16 (a) Informant Marcus Strickland
(b) Address same

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 18-1946 (month) (day) (year)
(c) Cemetery or crematory Greenville
Location South Carolina

18 (a) Funeral director Burgan Funeral Home
(b) Address 321 Halls Road

19 (a) (b)
(Date rec'd by registrar) (Registrar) Huntington Williams, M.D.

NOV 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1946 at 1:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1946 to Nov 18 1946, and that I last saw her alive on Nov 17 1946.

Immediate cause of death: Left heart failure
Due to Acute Pulmonary Edema
Due to Auricular fibrillation — Duration 11/13/46
Due to Arteriosclerotic C-V disease and Stroke — 11/18/46
Other Conditions Cerebral Intracranial and cerebral hemorrhage
Date of operation (Month, day, year)
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward D. Sauerwein
Address Franklin Square Hospital Date signed 11/18/46

G15618 — BALTIMORE CITY HEALTH DEPARTMENT — G15618
Registered No.

CERTIFICATE OF DEATH 97

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 Keyworth Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Keyworth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Cohen Higger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Goodman

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 75 | Months | Days | If less than one day: hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Yehuda Cohen
13. Birthplace Lith

MOTHER
14. Maiden Name Rebecca
15. Birthplace Lith

16 (a) Informant Mrs Golgie Sekenberg
(b) Address 2528 Keyworth Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-18-46 (month) (day) (year)
(c) Cemetery or crematory
Location Druzhans N. C.

18 (a) Funeral director Jack Lewis Inc
(b) Address 4[illegible] Balto St

19 (a) NOV 18 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18- 1946 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19 to Nov 18 1946 and that I last saw h[illegible] alive on Nov 17 1946

Immediate cause of death: general cerebral arteriosclerosis — Duration: 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4704 Park Rd Date signed 11/19/46

X

G45615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G45615 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D O A
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3629 Keswick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilbur Baldwin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife Christina Baldwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1896

8. AGE: Years	Months	Days	If less than one day
50	5	25	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business Balto City Fire Dept

FATHER
12. Name Nathan Baldwin
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Mercer.
15. Birthplace Maryland

16 (a) Informant Mary Baldwin
(b) Address 3629 Keswick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road.

18 (a) Funeral director Ehrmantraut & Donovan
(b) Address 34 15 17 Eutaw Place

19 (a) NOV 18 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1946 at 12 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Ryan Sullivan Jr. M.D. Medical Examiner.
Date signed 11/16/46

VS 151

X

64561 bo

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C256180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Dillwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Girard Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert F. Hare.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Zola M. Hare. 6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 12 1863 or 1896

8. AGE: Years	Months	Days	If less than one day
63 ~~50~~	6	4	hrs. min.

9. Birthplace Maryland
(State, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Hare
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth Hare.
15. Birthplace Maryland

16 (a) Informant Zola M. Hare.
(b) Address 2008 Girard Ave

17 (a) Burial (b) Date thereof Nov 19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location

18 (a) Funeral director Edmund F. Donovan
(b) Address 3615-17 Eastern Ave.

19 (a) NOV 18 1946 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1946 at 6 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1946 to Nov 16 1946 and that I last saw h[illegible] alive on Nov 16 1946.

Immediate cause of death	Duration
Cardiac Decomp.	1 wk.
Due to Arteriosclerotic CVD.	3
Due to	
Other Conditions Generalized arthritis	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence J. Kinnamon M. D.
Address 311 Dillwood Date signed 11-22-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

(over)

C15617 C15617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 Berry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Berry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland S. Thomas.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Laura M. Thomas
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) May 15 1891

8. AGE: Years	Months	Days	If less than one day
55	6	2	hr. min.

9. Birthplace maryland.
(Town, county, and state)
10. Usual Occupation Office Clerk.
11. Industry or business

FATHER
12. Name Samuel Thomas
13. Birthplace maryland.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland.

16 (a) Informant Laura M. Thomas
(b) Address 800 Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Baltimore Md.

18 (a) Funeral director Chenowith & Donovan
(b) Address 2618 E. Baltimore Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1946, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 17 1946 and that I last saw him alive on Nov 16 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Coronary Occlusion	
Due to	
Other Conditions Cerebral hemorrhage	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature I. Horsley Rye M.D.
Address 601 N. Monroe Date signed 11/18/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15618
504606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G15618
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zozia Keith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? 09.

8. AGE: Years	Months	Days	If less than one day
37.			hr. min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Thompson
13. Birthplace Augusta Ga.

MOTHER
14. Maiden Name Anna Williams
15. Birthplace Augusta Ga.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Nov 19 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Charleston S. Carolina

18 (a) Funeral director Thos Scott A. Ellwood Dept
(b) Address 1129 N. Eastern St

19 (a) NOV 18 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1946 at 9.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1946 to Nov 15 1946 and that I last saw h[illegible] alive on Nov 15 1946.

Immediate cause of death	Duration
Cerebral hemorrhage, st. cerebrum (left)	24 hrs.
Due to hemiplegia.	
Subarachnoid hemorrhage	24 hrs.
Due to Hypertensive CV disease & Coronary enlargement	unknown
Other Conditions Hypertensive renal sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. J. Evans M. D.
Address Johns Hopkins Date signed 11/15/46

Original

VS 150

309285 G15619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G15619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Mareland, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Yetta Kitt
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Morris Kitt
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) 6-9-06
8. AGE: Years 40 Months 5 Days 9 If less than one day hr. min.
9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation hswf
11. Industry or business

FATHER
12. Name Louis Sperling
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Betusin
15. Birthplace Russia

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov (month) (day) (year)
(c) Cemetery or crematory South Hills Park
Location Balto Co. Md
18 (a) Funeral director Dillard Funeral Home
(b) Address 217 E. Lanvale Street
19 (a) NOV 19 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1946 at 5 30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-21- 1946 to 11-18- 1946 and that I last saw her alive on 11-18- 1946.

Immediate cause of death: Intestinal obstruction — Duration: 2 wks

Due to: Carcinoma, metastatic — ?

Due to:

Other Conditions: Ulcerative colitis Ileostomy — 11 yrs

(Include pregnancy within 3 months of death)

Date of operation 6 November 46

Major findings of operation: Metastatic carcinoma, bowel, liver, peritoneum

Result of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard D. Bush, M.D.
Address JHH Date signed 11-20-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G456 50 — BALTIMORE CITY HEALTH DEPARTMENT — G456 50

CERTIFICATE OF DEATH 477

Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, state RURAL and give town)
(d) Street No. 1316 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes M. Ottara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mathew J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1879

8. AGE: Years 67 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER 12. Name Unknown

13. Birthplace Lithuania

MOTHER 14. Maiden Name Unknown

15. Birthplace Lithuania

16 (a) Informant Mr Mathew J Ottara

(b) Address 1316 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director John J Conroy Son

(b) Address 901-03 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar Wilmington Williams

NOV 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/1946 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1946 to 11-16 1946 and that I last saw h er alive on 11-16-46 1946.

Immediate cause of death	Duration
Hemorrhage-Pulmonary right	5 mins
Shock	
Due to Carcinoma lung right	2 years
Due to	
Other Conditions Hypertension 200/100	years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Mendelis M. D.

Address 651 No Bentalou Date signed 11-18-46

X

G45650

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G45650 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 701 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace H. Sullivan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Charles E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1883

8. AGE: Years 63. | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER 12. Name John Whitford

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace Baltimore Md.

16 (a) Informant Mr Charles E. Sullivan

(b) Address 701 Washington Blvd

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof 11 (month) 19 (day) 46 (year)

(c) Cemetery or crematory Mt Olivet Cem

Location 3330 Frederick Ave

18 (a) Funeral director John J. Gorman & Son

(b) Address 401-03 E. Fallsway

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11, 16 1946, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1946 to Nov 16 1946, and that I last saw h alive on Nov 16 1946.

Immediate cause of death Auricular Fibrillation

Due to Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 Days
3 Weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cobb

Address 517 Scott St Date signed M. 11 D. 16/46

X

G45652 — BALTIMORE CITY HEALTH DEPARTMENT — G45652 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2829 Guilford avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2829 Guilford avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN STEWART

3 (b) If veteran, name war ---

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1886

8. AGE: Years 60 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name William Stewart
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Cora Demling
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. James O'Hare
(b) Address 2829 Guilford avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) Date received by registrar NOV 18 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1946 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1945 to 11/17 1946 and that I last saw h[illegible] alive on 17 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days

Due to: Arteriosclerosis — Duration Chronic

Due to: — Duration —

Other Conditions — Duration —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. J. Evans M. D.

Address 24[illegible] N. Paul St. Date signed 11/16/46

VS 150

G15653 B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G15653 B
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 — street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 51

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4917 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. John Hayes Flaherty

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-95

8. AGE: Years 51 | Months 0 | Days 6 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles Vincent Flaherty
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anastasia Hayes.
15. Birthplace Baltimore Md.

16 (a) Informant Hospt. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-46 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat.
Location Balto - Md

18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayette Sts.

19 (a) (Registrar's number) (b) Registrar

NOV 19 1946
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1946, 6:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1946, to Nov 17, 1946, and that I last saw him alive on Nov 17 1946.

Immediate cause of death: Heart Failure — Duration

Due to Severe Burns 2nd degree

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-13-46 at 10:10 P. M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(Gwynn Park)
(d) Did injury occur about home, on farm, industrial place, in public place? Gwynn R.R. bridge While at work? — —
(Specify type of place)
(e) Means of injury Burned over bon-fire

23. Signature Edwin A. Hendrickson M. D.
Address Union Memorial Hosp. Date signed

Dr. John R. Lord
Dr. Howard E. Sutherland

G15653 4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G15653 4

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Josephs Hospital
(c) Hospital or institution 1900 Caroline St. Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Beaumont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Lillian Cook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1876

8. AGE: Years	Months	Days	If less than one day
70	2	3	hr. min.

9. Birthplace Queen Anne Co Md (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER	12. Name Wm. Cook
	13. Birthplace Queen Anne Co
MOTHER	14. Maiden Name Ada Ruggold
	15. Birthplace Queen Anne Co

16 (a) Informant Mrs Nellie Cook
(b) Address Stevensville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (month) (day) (year)
(c) Cemetery or crematory Stevensville
Location Stevensville Md

18 (a) Funeral director Edgar L Lane
(b) Address Church Hill Md

NOV 19 1946 (Date received by Registrar) Huntingtown Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 - 1946, at 11.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1946 to Nov 18 1946 and that I last saw h alive on Nov 18 1946.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to CEREBRAL VASCULAR	
Due to ACCIDENT	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Richard A. Young
Address St Josephs Hosp. Date signed 11/18/46

VS 150

5655 — BALTIMORE CITY HEALTH DEPARTMENT — C15655

CERTIFICATE OF DEATH

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Euton Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Delaware (b) County
(c) City or town Wilmington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R Spencer

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Mary K.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept 20, 1863
8. AGE: Years 83 Months 1 Days 27 If less than one day hr. min.
9. Birthplace Lebanon Del (Town, county, and state)
10. Usual Occupation Car Builder Retired
11. Industry or business Ex RR

FATHER
12. Name Edward F Spencer
13. Birthplace Del

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Harvey W Spencer
(b) Address 2617 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 19 46 (month) (day) (year)
(c) Cemetery or crematory Mt Salem
Location Wilmington Del

18 (a) Funeral director Wilson Cox Inc
(b) Address 1217 St Paul St

NOV 19 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 - 1946, to Nov. 16 - 1946, and that I last saw h[illegible] alive on 11-16 - 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. Atherosclerosis	
Due to	
Other Conditions Chr Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J Gauch M. D.
Address 1700 Euton Pl Date signed 11-18-46

Correct age is especially important. Physicians: please write clearly and legibly. Strike the causes of death clearly and legibly.

VS 150

P 3a

G15656 — G15656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Juniper Road
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Juniper Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna E. Bolkey

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21, 1869

8. AGE: Years	Months	Days	If less than one day
76	11	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER — 12. Name Patrick J. King
13. Birthplace Ireland

MOTHER — 14. Maiden Name Celia Tootell
15. Birthplace Baltimore

16 (a) Informant Mrs. George Kuhness
(b) Address 3909 Juniperroad

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul Street
(c) [illegible] Huntington Williams, Mgr.

NOV 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1946, at 8.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1946 to Nov 17 1946 and that I last saw h[illegible] alive on Jan 12 1946

Immediate cause of death	Duration
Myocardial Insufficiency	3 months
Due to Arterio Sclerosis	3 yrs
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1 W. Eutaw Date signed 11/18/46

VS 150

Check age is especially important. Physicians: please write the causes of death clearly and legibly.

15659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G15659 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 - 10th St. - Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kirby Norris

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7333

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kathryn E. Norris

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Nov 15th 1879

8. AGE: Years 70 (73) Months 0 Days 3 If less than one day hr. min.

9. Birthplace Easton Md (town, county, or state)

10. Usual Occupation Retired Clerk

11. Industry or business Southern Hotel

FATHER
12. Name James Norris
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Kirby
15. Birthplace Md.

16 (a) Informant Kathryn E. Norris
(b) Address 3801 - 10th St. Brooklyn Md

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery Spring Hill
Location Easton Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St.
(c) (Director or Undertaker) Huntington Williams

NOV 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18th 1946. 11:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Nov. 18 1946 and that I last saw him alive on Nov. 18 1946.

Immediate cause of death coronary occlusion. — Duration Instant

Due to Thrombosis

Due to Senility & Hard arteries

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Date signed Nov 18 46

Correct age is especially important. Physicians: please write legibly.

VS 150

X

15658 — BALTIMORE CITY HEALTH DEPARTMENT — G15658 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1750 E. North Ave.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) X
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1750 E North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William P. Flint

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: X
6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.): June 26 1861

8. AGE: Years 85 | Months 9 | Days 19 | If less than one day hr. 10 min.

9. Birthplace Cambridge (Town, county, and state)

10. Usual Occupation Retired Lithographer

11. Industry or business

FATHER
12. Name Thomas M. Flint
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Flint
15. Birthplace Maryland

16 (a) Informant Wm Cook, Inc
(b) Address 1217 St Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 1946 (month) (day) (year)
(c) Cemetery ~~co-operative~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director Wm Cook, Inc
(b) Address 1217 St Paul Street
(c) Date received by registrar NOV 19 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1946 at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1946 to 11/15 1946 and that I last saw him alive on 11/15 1946.

Immediate cause of death: Cerebral hemorrhage — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roberta Reiter M. D.
Address 3408 Windsor Ave Date signed 11/16/46

VS 150

Correct age is especially important. Physicians: please write plainly and fill in all items. Indicate the causes of death clearly and legibly.

5659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G15659 Registered No. 9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Irvington (If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Massachusetts Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allan F. GIBBONS

3 (b) If veteran, name war	3 (c) Social Security Account No.
nd	

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Pauline Gibbons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20th 1886

8. AGE: Years	Months	Days	If less than one day
60	8	28	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Maintenance Machinist
11. Industry or business U. S. Ordnance Dept.

FATHER
12. Name Samuel Pillsbury Gibbons
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Theresa Mathis
(b) Address 4208 Massachusetts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Montgomery Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
(c) (Director or Deputy) Huntington Williams

NOV 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1946 at 9 50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner
Date signed 11/18/46

VS 191

15660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G15660

Registered No.

CWK-106166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Elizabeth (Kline) Klein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband/wife: Louis (Kline) Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8-1866

8. AGE: Years	Months	Days	If less than one day
80	7	10	hr. min.

9. Birthplace New York N.Y.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Nelson Stalker
13. Birthplace N.Y.

MOTHER
14. Maiden Name Carrie ?
15. Birthplace ?

16. (a) Informant Records-Balto. CityHospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westview
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
NOV 19 1946 Date rec'd by local registrar Clayton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 19 46 at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 19 46 to Nov. 18 19 46, and that I last saw h er alive on Nov. 18 19 46.

Immediate cause of death: Cardiac Failure — Duration: 3 mo

Due to: Hypertension — yrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Myocardial Infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balto City Hosp Date signed 11/18/46

5660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G15660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.,
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town St. Petersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Fourth Ave., North (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Goodwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/14/71

8. AGE: Years	Months	Days	If less than one day
75	3	24	hr. min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Thomas Goodwin
13. Birthplace Md.

MOTHER
14. Maiden Name Talia (Unknown)
15. Birthplace

16 (a) Informant Grace A. Smith
(b) Address 301 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

NOV 19 1946 Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH 11/18/46 19 , at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/46 19 , to 11/18/46 19 , and that I last saw her alive on 11/18/46 19 .

Immediate cause of death: Cardio resp. failure — Duration

Due to Carcinoma, metastatic primary, adeno-carcinoma, caecum

Due to with intestinal obstruction, partial.

Other Conditions

(Include pregnancy within three months of death)

Date of operation 10/18/46

Major findings of operation: Inoperable carcinoma of ceacum, infiltrating wall of the pelvis.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wells M.D.
M. D.
Address 1400 N. Caroline St Date signed 11/18/46

X

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Write the causes of death clearly and legibly. Physicians: please write

G15662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G15662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 Elsinore Ave
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltocity
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Elsinore Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Taylor Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Young A. Wilson, Jr.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1872

8. AGE: Years 64 | Months 2 | Days 9 | If less than one day: hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Wm H. Gibson
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden Name Caroline A. Taylor
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mary H. Bowerman
(b) Address 2609 Elsinore Ave - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-46 (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Westerstown, Md.

18 (a) Funeral director Stewart & Mower Company
(b) Address 108 W. North Ave - City

NOV 19 1946 (Date filed by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 17, 46 19 , at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1945 to NOV 17 1946 and that I last saw him alive on Oct NOV 16 1946.

Immediate cause of death: Coronary occlusion — Duration about 1hr

Due to: Advanced arterio sclerosis & Hypertension — Duration ?

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury —

23. Signature Hallie Stubblefield M. D.
Address 2220 Harrison Blvd Date signed NOV 18 46

VS 150

Correct age is especially important. Physicians: please write

G615663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G615663 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Windsor Mills (If outside city or town limits, write RURAL and give town)
(d) Street No. Quebec (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Canada

3 (a) FULL NAME Bertha Stalkin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife A. S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-29 1876

8. AGE: Years	Months	Days	If less than one day
70	8	17	hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Suffron
13. Birthplace Canada

MOTHER
14. Maiden Name Nancy Davis
15. Birthplace Canada

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/17/46 (month) (day) (year)
(c) Cemetery or crematory
Location Windsor MillsQuebec, Canada

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) (Registrar) (b) Huntington Williams, M.D. Registrar

NOV 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1946 at 12 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1946 to Nov. 16 1946 and that I last saw h.er alive on Nov. 16 1946.

Immediate cause of death	Duration
1 Coronary occlusion	
Due to Hypertension Cardiovascular Disease	
Due to Arteriosclerosis, generalized	
Other Conditions Emphysema Chronic infection Alcoholism bronchitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: —
of autopsy —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Wm. S. Gould M. D.
Address Johns Hopkins Hosp. Date signed

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G45664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G45664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 N Curley St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 N Curley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna A Ulbrich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 1874

8. AGE: Years	Months	Days	If less than one day
72		15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name August Hergenroeder
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Neuslein
15. Birthplace Germany

16 (a) Informant Mrs Joseph Gunzelman
(b) Address 816 N Curley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St
19 (a) Nov 19 1946 Huntington Williams, M.D. Address 701 N. Howard St

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1946, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1946 to Nov. 16 1946, and that I last saw h alive on Nov 16 1946

Immediate cause of death	Duration
Coronary occlusion	6 days
Due to	
Due to	
Other Conditions Art. Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm J Schmitz M.D.
Date signed 11/20/46

NOV 19 1946

VS 150

X

Correct age is especially important. Physician: please write clearly and legibly.

15665 BC# 90 61902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G15665 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3457 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Hicks

3 (b) If veteran, name war —
(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 46

8. AGE: Years	Months	Days	If less than one day
			4 hr. 1/2 hr. 5 min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name , , ,
13. Birthplace , , ,

MOTHER
14. Maiden Name Bertha Hicks
15. Birthplace Md

16 (a) Informant Records –
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 19 1946 (Date rec'd by registrar) (By) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13. 1946 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1946 to Nov 13 1946 and that I last saw him alive on Nov. 13 1946

Immediate cause of death	Duration
Prematurity	
Due to Premature labor (twin)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan
Address 809 N Broadway Date signed Nov 14 46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

5666 Birth Certificate G. 69147 G15666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160 C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Mura St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Dobbs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-46.

8. AGE: Years | Months | Days | If less than one day: 2 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Dobbs
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 15 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 19 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11- 1946 at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death: Neonatal asphyxia
Prematurity
Due to Prolapse cord
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Adams M. D.
Address Johns Hopkins Hosp. Date signed 11-11-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

5667

G45667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Riva
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Singleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			9 hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Singleton
13. Birthplace Ohio

MOTHER
14. Maiden Name Gertrude Risquet
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 19 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946 at 4:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 12 1946 to Nov 13 1946 and that I last saw he alive on Nov. 13 1946

Immediate cause of death PREMATURITY — Duration Hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul H. Harden M. D.
Address Johns Hopkins Hosp. Date signed 11/13/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

15668 BC-7F G61564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G45668 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Maryland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME King

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8, 1946

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jesse King
13. Birthplace South Carolina

MOTHER
14. Maiden Name Lillian Yancey
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 19 1946 Huntington Williams M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 19 46 11:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 19 46 to Nov. 11 19 46 and that I last saw h im alive on Nov. 11 19 46

Immediate cause of death: Premturity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Arden M.D.
Address Johns Hopkins Hospital Date signed 11-11-46

VS 150

X

G15669

B.C. B-45669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

Registered No. G15669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Lytle St.
(c) Hospital or institution: South Baltimore Gen'l Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 20 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Columbia Ave 12
(If rural give location)
(e) Citizen of foreign country? Naid (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores Schrander

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11, 1946

8. AGE: Years	Months	Days	If less than one day
			20 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Joseph Schrander
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothy Jeanette Buck
15. Birthplace Baltimore

16 (a) Informant mother - Dorothy Schrander
(b) Address Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 19 1946 Huntington Williams MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Nov 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1946 to 11/12 1946 and that I last saw he/she alive on 11/12 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary Atelectasis & Edema	
Due to Patent ductus arteriosus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis - Patent ductus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cohen

Address South Balto Gen'l Hosp Date signed M. 11 D. 15/46

VS 150

G15670

D.C. # 62128

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G15670 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4720 Delaware Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1946

8. AGE: Years	Months	Days	If less than one day
			1 hr. 56 min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Clion Wright Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha May Swinney
15. Birthplace Baltimore, Maryland

16 (a) Informant Bertha Wright
(b) Address 4720 Delaware Ave. Balto 5

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 19 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1946, at 9 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1946, to Nov 13 1946, and that I last saw him alive on Nov 13 1946.

Immediate cause of death	Duration
atelectasis	1 hr 56 min
Due to premature	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary Dykeman M. D.
Address Womens Hosp. Date signed 11-16-46

X

15671 BC# G 61903 BALTIMORE CITY HEALTH DEPARTMENT G15671

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3457 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hicks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-13-46

8. AGE: Years | Months | Days | If less than one day: 11 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ? ?
13. Birthplace ? ? ?

MOTHER 14. Maiden Name Bertha Hicks
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 19 1946 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-13- 1946, at 11. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-13 1946, to Nov-13 1946, and that I last saw h[illegible] alive on Nov-13 1946.

Immediate cause of death — Duration

Prematurity

Due to Premature Labor (Twins)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address 720 N. Broadway Date signed Nov 14 46

VS 150

correct age is especially important. Physicians: please write

BALTIMORE CITY HEALTH DEPARTMENT

G45672 **CERTIFICATE OF DEATH** 1937 Registered No. G45672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3551 Buena Vista ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3551 Buena Vista ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Lovell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Thomas W Lovell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 17 - 1864

8. AGE: Years	Months	Days	If less than one day
82	4	29	hr. min.

9. Birthplace York Co. Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name John McConnell
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Hoffacker
15. Birthplace Germany.

16 (a) Informant Mrs Jessie Wright
(b) Address 3551 Buena Vista ave

17 (a) Burial (b) Date thereof 11/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mary's (Hampden)
Location Baltimore Md

18 (a) Funeral director Geo K Beyer Jr
(b) Address 1512 Hollins St

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1946 at 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to 11-16 1946, and that I last saw h[illegible] alive on 11-16 1946.

Immediate cause of death	Duration
Cerebral Thrombosis	3 da.
Due to Arteriosclerotic CVD	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence J Lamond
Address 3711 Dalrymple Date signed 11-18-46

Correct age is especially important. Physicians: please write legibly.

G45673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G45673 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 S Bruce St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Mayer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-7524

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Ethel K Mayer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 8 1883

8. AGE: Years	Months	Days	If less than one day
63	10	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business —

FATHER
12. Name Charles Mayer
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Ethel K Mayer
(b) Address 214 S Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo F Boyer Jr
(b) Address 1512 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1946, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1941 to Nov 18 1946 and that I last saw h[illegible] alive on Nov 17 1946

Immediate cause of death
Cardiac Decompensation — Duration 2 wks

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Alberta H Katz M. D.
Address 2030 Walbrook Ave Date signed Nov 18 1946

Nov 20 1946 Huntington Williams, M.D.

X

correct age is especially important. Physicians please

G15674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 c ✓

Registered No. G15674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Lee St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Lee St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Browning

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-8615

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maria C. DeSalvo | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/25/1885

8. AGE: Years 61 | Months 1 | Days 23 ?2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Metropolitan Bank

FATHER
12. Name Joseph Browning
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary C Kyne
15. Birthplace Ireland

16 (a) Informant Mrs Joseph J Browning
(b) Address 138 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director J. J. Flanagan & Son
(b) Address 138 Light St.

19 (a) NOV 19 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1946 to 11/17 1946 and that I last saw him alive on 11/17 1946.

Immediate cause of death	Duration
(a) Chronic Endocarditis	2 mo.
Due to (b) Chronic Rheumatism	5 mo.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1274 Williams St Date signed 11/18/46

Huntington Williams, M.D.

correct age is especially important. Physicians: please write

X

5675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97E

G45675 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Rockemp Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Kohler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1906

8. AGE: Years	Months	Days	If less than one day
40	8	0	hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Michael Sullivan
13. Birthplace Penna

MOTHER
14. Maiden Name Susan Dragon
15. Birthplace Penna

16 (a) Informant Mr. Kohler
(b) Address 3210 Rockemp Ave

17 (a) removal (b) Date thereof 11 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Penna.

18 (a) Funeral director Philip Hering Sons
(b) Address 227 Calhoun ST

19 NOV 19 1946 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1946, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1946, to Nov 19 1946, and that I last saw him alive on Nov 19 1946.

Immediate cause of death
Cardio-respiratory failure
Due to the following conditions
Due to recent jaundice
Other Conditions undetermined

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry T. Wilson, Jr. M. D.
Address St Joseph's Hosp Date signed 19 Nov 46

VS 150

X

G45676

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 46 D

G45676 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd ST.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 WESTWOOD AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BRIDGES FREY.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 28, 1900

8. AGE: Years	Months	Days	If less than one day
46	2	20	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation AUDITOR.

11. Industry or business Racing Commission

FATHER 12. Name ROGER A. FREY

13. Birthplace BALTIMORE, MD.

MOTHER 14. Maiden Name ROSE SAUNER.

15. Birthplace BALTIMORE, MD.

16 (a) Informant Miss EDNA MAHE.

(b) Address 1917 ROSEDALE ST. BALTO. MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) ~~NOV 19 1946~~ (Registrar's signature) Huntington Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 18, 1946, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 12 1946 to NOV. 18, 1946 and that I last saw him alive on NOV. 18, 1946.

Immediate cause of death	Duration
METASTATIC CARCINOMA	
Due to CARCINOMA OF RECTUM	19 Mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.

Address [illegible] signed 11/20/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1639

Registered No. G45677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Anthony KEYS

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-0605

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 4 1880

8. AGE: Years	Months	Days	If less than one day
66	6	15	____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Civilian Storekeeper
11. Industry or business U. S. Naval Stores

FATHER
12. Name William Wesley Keys
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah E. Law
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Clara Keys
(b) Address Baltimore, 16, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1946 (Date rec'd by registrar) (b) Huntington Maryland

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1946 at 11:25 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cyanide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-16-46 at 2 P. M.
(b) Where did injury occur? 225 E. Biddle Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Cyanide

23. Signature George H. Merrell M.D. Medical Examiner.
Date signed 11/18/46

G15678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G15678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700- Labyrinth Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. STRAUS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Spanish Am.	none	Male	White	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1875

8. AGE: Years	Months	Days	If less than one day
71	5	11	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Straus
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Rosalie E. Ellinger
15. Birthplace Balto., Md.

16 (a) Informant Mr. Theodore Straus, Brother
(b) Address 4700 Labyrinth Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 191 NOV 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1946, 6.15a.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/18/46

5679 ✓ G45679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAFAYETTE GRAVES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation
11. Industry or business Unknown

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant None
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 7 9 1946 Hunter Van Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1946, at 3:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage (subdural)
Bronchopneumonia
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 11-2-46 at about ? M.
(b) Where did injury occur? cellar in front of home
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Found lying outside

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/5/46

15680

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 30E V Registered No. C75650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Detroit (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Epps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 19?

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?
11. Industry or business Unknown

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant None
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address
NOV 19 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1946, at 4 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure.
Coronary Disease
Due to Chronic Valvulitis - Aortic - Mitral
Syphilitic Aortitis.
Other Conditions Hypertrophy, Arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 11-4-46

X

G15681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G15681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Darley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Wills

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18-1906

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	2	0		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation C. P. A.
11. Industry or business

FATHER
12. Name Charles L. Wills
13. Birthplace Md

MOTHER
14. Maiden Name Wilhelmina Haid
15. Birthplace Md

16 (a) Informant Mr. Wm. Wills
(b) Address 1205 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (d) NOV 19 1946 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1946, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946, to Nov 18 1946, and that I last saw h[illegible] alive on Nov. 18 1946.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Rheumatic heart disease	
Due to Mitral insufficiency and Stenosis	
Other Conditions Polycythemia Vera, L.P.L. Chronic Pulmonary Congestion & Atelectasis	

(Include pregnancy within 3 months of death. Etc.)
Date of operation
Major findings of operations: Autopsy
of autopsy: Autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Bassoe M.D.
Address Sinai Hospital Date signed 11/18/46 M. D.

VS 150

Testing for William

G15682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

G15682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 566 Preston Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 566 - N. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no.

3 (a) FULL NAME Ida Garritt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1904

8. AGE: Years	Months	Days	If less than one day
42	5	7	hr. min.

9. Birthplace Lawrenceville, Va. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name George Jarritt
13. Birthplace Virginia

MOTHER
14. Maiden Name Lizzie Kelly
15. Birthplace Virginia

16 (a) Informant Pearl Garritt
(b) Address 566 - N. Preston St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 20 1946 (month) (day) (year)
(c) Cemetery Location La-Cross, Va. La-Cross - Va.

18 (a) Funeral director Ira Halstead
(b) Address 916 Druid Hill Ave.

19 (a) Dated (b) Signature (Registrar) Ellington Williams, M.D. Registrar

Nov 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1946 to 11-16 1946 and that I last saw h alive on 19

Interval between onset and death — Duration 2 Days

Immediate cause of death: Lobar Pneumonia

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Atwell Jones, M.D.
Address 5-35 Dolphin St. Date signed 11-18-46

VS 150

G15683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G15683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 N. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 N. Caroline St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Peter Mitchell

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1892

8. AGE: Years	Months	Days	If less than one day
54	3	2	hr. min.

9. Birthplace Westmorland Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Banks
13. Birthplace Va

MOTHER
14. Maiden Name Belle Washington
15. Birthplace Va

16 (a) Informant Peter Mitchell
(b) Address 1107 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md.

18 (a) Funeral director Detrick Manning & Wright
(b) Address 721 Pasquith St

19 (a) (Date filed by registrar) (b) Registrar

NOV 19 1946

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1946, at 2:15 A.M.

21. I certify that death occurred on the date above stated; that I first attended deceased from July 12 1946 to November 15 and that I last saw her alive on Nov. 15 1946

Immediate cause of death Hypertensive type heart disease — Duration

Due to

Due to

Other Conditions Diabetes Interstitial nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin A. Bickes, M.D.
Address 601 N. Calhoun St. Date signed 11/19/46

93D

Street age is especially important. Physician: please write the causes of death clearly and legibly.

G15684 BALTIMORE CITY HEALTH DEPARTMENT G15684
CERTIFICATE OF DEATH 467 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Brunt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Porter, Richard Asbery
3 (b) If veteran, name war WWI
3 (c) Social Security Account No. --
4. Sex M
5. Color or race Col
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Susie Cherry Porter
6 (c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) Oct. 6, 1896
8. AGE: Years 50 Months 1 Days 12 If less than one day hr. min.
9. Birthplace Anne Arundel Co. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business --

FATHER
12. Name James Porter
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Martha Smith
15. Birthplace Maryland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 11-22-46
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Magothy Cemetery
Location A. A. County Md.
18 (a) Funeral director William Treakle
(b) Address 916 Pelham ave
19 (a) (b) Williamsport, Md.
(Date rec'd by registrar) (Registrar)
NOV 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1946, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov. 18 1946, and that I last saw him alive on Nov. 16 1946

Immediate cause of death: Metastatic adenocarcinoma of liver, massive secondary to adenocarcinoma of rectum, resected Apr. 1946 — Duration UNKNOWN

Due to — UNKNOWN

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: As above

PHYSICIAN'
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/18/46

G15685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170 C

Registered No. G15685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 342 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Williams

3 (b) If veteran, name war W. W. 2

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-25-1902

8. AGE: Years 44 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Portsmouth Va (town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name John Williams
13. Birthplace Va

MOTHER 14. Maiden Name Anna Rivers
15. Birthplace Va

16 (a) Informant Bernice Williams
(b) Address 1342 Argyle ave

17 (a) Burial (b) Date thereof 11 21 46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Lorbutas Mem Park
Location Baltimore County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) NOV 19 1946 (b) Registrar Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1946 at 7 30 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Broken neck (2nd and 3rd cerv. vertebrae)

Due to

Other Conditions Subdural hemorrhage, Edema of the Lungs, Ruptured Kidney, etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-18-46 at 7 15 A. M. 4/2
(b) Where did injury occur Greene & Saratoga Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Streets While at work? No
(d) Means of injury Fell struck by truck when he ran across street

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 11-19-46

VS 191

G45686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G45686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Edythe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and name town)
(d) Street No. 1226 Edythe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hallie Fountain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Sep

6 (b) Name of husband or wife Richard Fountain

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/15/19[illegible]

8. AGE: Years	Months	Days	If less than one day
31	6	1	hr. min.

9. Birthplace Hanover Co. Va (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Dollie Thomas
15. Birthplace Va

16 (a) Informant Nannie Thomas
(b) Address 1522 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory
Location Ashland Va.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantly Ave

19 (a) (b)
(Signature of registrar) Huntington Phillips, M.D.

NOV 19 1946

V S-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16th 1946 at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased at 11-14 1946 to 19 ; and that I last saw h[illegible] alive on 11-14 1946.

Immediate cause of death Marasmus

Due to Suspected TB of lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
couple of years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Karl Trought M. D.
Address 1623 E. N. Avenue Date signed 11-18-46

X

G15687 ✓ G15687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 106a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 N. Chapel St
(c) Hospital or institution:

8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Varga Kotchen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Joseph Kotchen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3rd 1903

8. AGE: Years	Months	Days	If less than one day
43	7	13	hr. min.

9. Birthplace Phoenixville, Pa.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name John Varga
13. Birthplace Hungary
14. Maiden Name Mary Vojcovitz
15. Birthplace Hungary

16 (a) Informant Wm. Varga
(b) Address 1801 N. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A & Co.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (b) Registrar

NOV 19 1946

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16th 1946, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1946, to Nov 16 1946.
and that I last saw him alive on Nov 16 1946.
Immediate cause of death Cardiac Dilatation
Acute Bronchitis
Duration 10 days 2 wks 6 months
Due to Myocardial Insufficiency
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Rosenberg
Address 2026 E. North Ave. Date signed 11-18-46

X

JL - 106849
G15688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓G15688 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Preston Smith

3 (b) If veteran, name war None
3 (c) Social Security Account No. 218-03-1215

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Virginia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1910

8. AGE: Years	Months	Days	If less than one day
36	2	11	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Belle Isle Corp.

FATHER
12. Name John Adams Smith
13. Birthplace ?

MOTHER
14. Maiden Name Agnes Miles
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Co.
Location Baltimore, Md.

18 (a) Funeral director Robert L. Cromwell
(b) Address 1216 E. Cathedral St.

19 (a) (b) Huntington Williams, M.D.

NOV 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1946 19 at 3:45p M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1946 to Nov. 17 1946, and that I last saw h 12 alive on Nov. 17 1946

Immediate cause of death Uremia — Duration

Due to Malignant hypertension and cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Wyle Walker M. D.
Address B.C.H. Date signed 11/18/46

G15689 | BALTIMORE CITY HEALTH DEPARTMENT | G15689

CERTIFICATE OF DEATH

Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Road
(c) Hospital or institution: Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Lakewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LULU M. CRAWFORD

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: James M. Crawford
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Mar. 31, 1867
8. AGE: Years 79 | Months 7 8 | Days 17 | If less than one day: hr. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William George
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Susan Ingram
15. Birthplace: Virginia

16 (a) Informant: Wilbur J. Crawford
(b) Address: 1608 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/ 20/46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) NOV 19 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1946 at 9.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1946 to Nov 17 1946, and that I last saw her alive on Nov 17 1946.

Immediate cause of death: Uremia - Chronic Nephritis
Contrib - vascular renal disease
Due to arteriosclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations: —

of autopsy: —

Duration: 11/15/46 —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Louis T. Krumrein M. D.
Address 7227 N. Kenwood Date signed Nov 18 '46

G15690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G15690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 North Carolina Ave.SE
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Smith, Virginia Lee

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Raymond C. Smith
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1920

8. AGE: Years	Months	Days	If less than one day
26	9 10	12	hr. min.

9. Birthplace Tangier, Va.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Sidney F. Crockett
13. Birthplace Tangier, Va.

MOTHER
14. Maiden Name Florence Crockett
15. Birthplace Tangier, Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-22,1946 (month) (day) (year)
(c) Cemetery or crematory Tangier Island
Location Tangier Island

18 (a) Funeral director Howard Hubbard
(b) Address Crisfield, Md.

19 (a) NOV 19 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 19 46, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 19 46 to Nov. 18 19 46 and that I last saw h. er alive on Nov. 18 19 46

Immediate cause of death Leukemia, myelogenous, acute — Duration ABOUT ONE MONTH

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 11/18/46

Kenneth [illegible] Registrar

VS 150

correct age is especially important. Physicians: please write the

G15691 ✓ G15691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street ~~Office~~ 3331 ~~3301~~ Moravia Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3331 ~~3301~~ Moravia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HEDWIG F. DREILING

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry W. Dreiling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 18, 1877

8. AGE: Years	Months	Days	If less than one day
69	8	0	hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown - Schulz
13. Birthplace: Germany

MOTHER
14. Maiden Name: Leugdke
15. Birthplace: Germany

16 (a) Informant: Mrs. Elsa D. Peterson
(b) Address: 3331 Moravia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory: St. Matthews Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

28. DATE OF DEATH Nov 18 1946, at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943 to Nov 18, 1946, and that I last saw h[illegible] alive on Nov 18 1946.

Immediate cause of death: Hemiplegia — Duration: 12 yrs

Due to: Hypertension — Duration: 22 yrs

Due to: Myocarditis — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Coral Gordon
Address: 2201 W. North Ave. Date signed: 11-[illegible]-46 M. D.

Coral Gordon

G15692 BALTIMORE CITY HEALTH DEPARTMENT G15692
CERTIFICATE OF DEATH
Registered No. 77c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Baltimore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Reed

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
White	Male	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Reed
13. Birthplace Belmont Ohio

MOTHER
14. Maiden Name Mary Wyandt
15. Birthplace Belmont Ohio

16 (a) Informant Fannie N. Desvoignes
(b) Address Mt Eaton Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Cem.
Location Belmont Ohio

18 (a) Funeral director Charles E. Delaney
(b) Address Edlich & Colyer

19 (a) (b)
NOV 19 1946 Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1946, at 3 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 11-19-46

X

G15693
AB-27841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122a

G15693
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9yrs- 0Months- 20days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Hefer St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Lynch

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife: Lillian (D
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 6- 1870

8. AGE: Years	Months	Days	If less than one day
76	10	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Weaver
11. Industry or business Retired

FATHER
12. Name Abraham Lynch
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Kidd or Sarah Scharff
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Geo. J. Schwat
(b) Address 2421 Eldorado Ave.

NOV 20 1946
19 (a) (Date rec'd by registrar) (b) Lington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18- 1946 at 8.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1937 to 11-18 1946, and that I last saw h 18 alive on 11-18 1946

Immediate cause of death Coronary Thrombosis Lobar and Bronchopneumonia, L. lung — Duration

Due to

Due to

Other Conditions Hemangioma of liver, Enlarged thyroid, Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation Oct. 22, 1946

Major findings of operation: Strangulated inguinal hernia, left.

of autopsy: Dr. Abare

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. D. Gibbs
Address Baltimore City Hosp. Date signed 11/19/46

VS 150

G15691 BALTIMORE CITY HEALTH DEPARTMENT G15691
CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 55Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 W. North Ave.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Max L. Millison

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Late Lena H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1871

8. AGE: Years 75 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Harry Millison
13. Birthplace Russia

MOTHER
14. Maiden Name Unknow
15. Birthplace Russia

16 (a) Informant Mrs Sara Meyers
(b) Address 2421 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20/46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philada Rd & Hamilton ave

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1134-36 W. North ave

19 (a) NOV 20 19[illegible] at Washington Hillsboro, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1946, at 4p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 to Nov. 19 1946 and that I last saw h[illegible] alive on Nov 19 1946.

Immediate cause of death: Cardiac Degeneration — Duration 2
Due to Arterio Sclerosis — ?
Due to Senility — (?)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel E. Boyd M.D.
Address 1905 W. Balto. St. Date signed 11/19/46

VS 130

D 45695

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G15695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5211 Eleanora Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5211 Eleanora Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aldina Mary Field

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Benjamin F. Field
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1890

8. AGE: Years	Months	Days	If less than one day
56	6	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Conard
13. Birthplace France

MOTHER
14. Maiden Name ? Travis
15. Birthplace Belgium

16 (a) Informant Benjamin F. Field
(b) Address 5211 Eleanora Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Date received NOV 20 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1946, at 9:25 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1946 to Nov 18 1946, and that I last saw h alive on Nov 17 1946

Immediate cause of death

	Duration
Chr. Myocarditis	1945
Due to Chr. Parenchymatous nephritis	1945
Due to	
Other Conditions Diabetes	1946

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul A. Dorn M. D.
Address 1600 Wolfe St Date signed 11/19/46

VS 150

1210

G15696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G15696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 842 Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Mattson

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wilbur A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About Oct 1874

8. AGE: Years 72 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Smallwood
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Jackson
15. Birthplace Maryland

16 (a) Informant Wilbur A Mattson
(b) Address 842 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/46 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilbur Cook Sr
(b) Address 1219 Ft Pond St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS/150 NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1946 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946, to 19 Nov. 1946, and that I last saw h[illegible] alive on 18 Nov. 1946.

Immediate cause of death — Duration

Due to Cancroma of Cervix with generalized Metastasis 18 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd C. Saylor M. D.
Address 3902 Greenmount Ave Date signed 19 Nov 1946

X

G15697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 587

G15697 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road & Herring Run.
(c) Hospital or institution: Sydenham Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED Anne Arundel
(a) State Md. (b) County Baltimore
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 2nd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME FRANK ARTHUR TUREK

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 10-16-35

8. AGE: Years	Months	Days	If less than one day
11	1	3 2	hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business —

MOTHER FATHER

12. Name Frank J. Turek
13. Birthplace Baltimore, Md.
14. Maiden Name Alice Clark
15. Birthplace Baltimore, Md.

16 (a) Informant Frank J. Turek
(b) Address 4109 2nd St, Brooklyn Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19-46 19____, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1946, to 11-19 1946, and that I last saw h[illegible] alive on 11-19 1946.

Immediate cause of death Cardiac failure.

Due to Rheumatic Heart Disease

Due to ____

Other Conditions Rheumatic fever.

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ____

23. Signature [signature] M. D.

Address Sydenham Hosp Date signed 11/19/46

X

correct age in especially important cases, please write

G15698 G15698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook + Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2951 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry Dehn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 - 1879

8. AGE: Years	Months	Days	If less than one day
66	10	20	hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William Dehn

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Katherine Gleuser

15. Birthplace Germany

16 (a) Informant Mrs. Gordon Roberts

(b) Address 4632 Asbury ave

17 (a) Burial (b) Date thereof 11/20/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery
Location Taylor ave

18 (a) Funeral director Howard N. Bligh Jr

(b) Address 4914 Belair Road

19 (a) Date received NOV 20 1946 Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 '46 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1946 to 11-17 1946.
and that I last saw her alive on 11-17 1946

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions Asthma, Bronchial
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Coronary Occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Sutton Smith Jr. M.D.

Address St Agnes Hosp. Date signed 11/18/46

VS 150

X

G15699

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G15699 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2219 Gough Ste
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Gough Ste.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kostanty Brulinski

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-1536

4. Sex M.

5. Color or race Wh.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Julie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24-1872

8. AGE: Years 74 Months 01 Days 3 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unk
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Mrs. Adam
(b) Address 2219 Gough Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location O'Donnell St. & Rd.

18 (a) Funeral director Jos. S. Fialkowski
(b) Address 2007 Eastern Ave.

19 (a) (b) Huntington Williams, M.D.

NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 19 46 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10/46 to 11/19/46 19..; and that I last saw h/M alive on 11/19/46.

Immediate cause of death Pneumonia — Duration 9 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Newsome M. D.
Address 1016 S. Eastern Ave. Date signed 11/19/46

VS 180

G15700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1124 B

Registered No. G15700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 S Rose St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin Stachowski
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-26-1632
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 5-1881
8. AGE: Years 65 Months 1 Days 13 If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Stachowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Martin Stachowski Jr.
(b) Address 811 S. Rose St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem. Location O'Donnell Hts Rd
18 (a) Funeral director Wm J. Falkowski
(b) Address 2007 Eastern Ave.
19 (a) NOV 20 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1946, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945, to Nov 18 1946, and that I last saw h[illegible] alive on November 18 1946.

Immediate cause of death	Duration
Cirrhosis of Liver	
Due to	
Due to	
Other Conditions Essential Hypertension, Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [signature] M.D.
Address 1[illegible] Date signed 11-18-46

X

G15701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1121a

G15701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ann Freeburger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. J. Freeburger
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 28, 1895

8. AGE: Years	Months	Days	If less than one day
51	4	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Stephen Ellwood
13. Birthplace Baltimore Co, Md

MOTHER
14. Maiden Name Elizabeth C. Murphy
15. Birthplace Ireland

16 (a) Informant Miss Carolyn Freeburger
(b) Address 919 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 NOV 20 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11. 18. 1946, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 11/K 1946, and that I last saw h alive on 11/18 1946.

Immediate cause of death Glomerular Nephritis — Duration 2 weeks
Due to Malignant Hypertension — Duration 2
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M. D.
Address 206 E. Preston St Date signed 11/19/46

Dr. T. Hawkins G15703

G15703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Division St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1895

8. AGE: Years	Months	Days	If less than one day
50 51	11	24	hr. min.

9. Birthplace Baltimore, Md.
(town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hatter Gibson
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Emma Jamison
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Florence Cattmary
(b) Address 1219 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Law. H. Holland
(b) Address 1691 Druid Hill Ave.

19 NOV 20 1946 [illegible] Washington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1946, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 17 1946 and that I last saw h[illegible] alive on Nov 15 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hunt Hawkins M. D.
Address 212 Druid Hill Ave Date signed Nov 20 46

VS 150

G15703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1832

Registered No. G15703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1143 Park ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 Park ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Coward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Cynthia Coward

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name William Coward

13. Birthplace N. C.

MOTHER 14. Maiden Name Miranda Dorsey

15. Birthplace N. C.

16 (a) Informant Cynthia Coward

(b) Address 1143 Park ave

17 (a) Burial (b) Date thereof 11/20/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 20 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION 6.50 PM

20. DATE OF DEATH 11/16/46 19 at 6.50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1946 to 11/16 1946 and that I last saw him alive on 11/16 1946

Immediate cause of death Cerebral Hemorrhage 1 day — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Dawelcome

Address 131 Harlem Ave Date signed 11/19/46

G15701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. G15701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 N. Arlington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 16
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Arlington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Larry Smarts

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-4-1883

8. AGE: Years 61 | Months 3 | Days 13 | If less than one day ___ hr. ___ min.

9. Birthplace Howard Co. Md (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15 Birthplace

16 (a) Informant Mary Smart
(b) Address 701 N Arlington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-46 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Baltimore Md

18 (a) Funeral director Wellyna Jackson
(b) Address 916 Pennsylvania ave

19 (a) ___ (b) ___

Filed NOV 20 1946 Washington Williams, REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1946, at 8 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1946 to 11-18- 1946, and that I last saw him alive on 11-17 1946.

Immediate cause of death: Uremic Coma - Kidney disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 mos x days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Jackson M. D.
Address 600 N Eutaw St Signed 11/20/46

X

615705 BALTIMORE CITY HEALTH DEPARTMENT 1946 Registered No. 615705

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Chapel Gate Lane
(c) Hospital or institution: Pinecrest Sanitorium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Smithsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. COOMBS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed or divorced. Widowed | 6 (b) Name of husband or wife Coombs | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-13-1864

8. AGE: Years 82 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Washington Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Hezekiah Holtzman
13. Birthplace Wash. Co. Md

MOTHER 14. Maiden Name Jane Fulton
15. Birthplace Wash Co Md

16 (a) Informant Mary Pryor
(b) Address Ft. Howard, Md

17 (a) Burial (cremation, or removal) (b) Date thereof 11-[illegible]-46 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Frederick Co (Border)

18 (a) Funeral director Geo. B. Hoover
(b) Address Smithsburg, Md

19 (a) (Date rec'd by registrar) (b) Registrar

VS NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 20 1946, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 11/20 1946, and that I last saw h[illegible] alive on 11/20 1946.

Immediate cause of death: Myocardial Infarct — Duration: 3 Months
Due to
Due to
Other Conditions: Arteriosclerosis with hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damian P. Alayca M. D.
Address 53 Hedgesville [illegible] signed

Ballard X

G15706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G15706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dix
(c) Hospital or institution: Franklin Square Hospital 19W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Iva Virginia Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C	Married

6 (b) Name of husband or wife Eddie Payne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2. 1897

8. AGE: Years	Months	Days	If less than one day
49	8	16	hr. min.

9. Birthplace Charles County Maryland
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business Johns Hopkins Hospital

FATHER
12. Name Philip Martin
13. Birthplace Charles County Maryland

MOTHER
14. Maiden Name Annie Washington
15. Birthplace Charles County Maryland

16 (a) Informant Eddie Payne
(b) Address 115 N. Bruce stuet

17 (a) Burial (b) Date thereof Nov. 22. 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ARLUS MEMORIAL PARK
Location Baltimore County

18 (a) Funeral director Joseph A Sisly
(b) Address 409 N. Mount street

19 (a) Huntington Williams M.D.

NOV 20 1946

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1946, at 2° A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial
Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schumaker M.D.
Medical Examiner.
Date signed 11/19/46

X

G15707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G15707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 Chelsea ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Betterton, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen May Silcox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wh.	Widowed

6 (b) Name of husband or wife Thomas Silcox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1879

8. AGE: Years	Months	Days	If less than one day
67	9 10	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H. Kelley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Harriet Cross
15. Birthplace Baltimore, Md.

16 (a) Informant Harriet V. Fisher
(b) Address 1900 Chelsea ave

17 (a) Burial (b) Date thereof Nov. 20 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director B. R. Fellows
(b) Address Pond, Md.

NOV 20 1946
(Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1946, at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1946, to Nov. 17, 1946, and that I last saw her alive on Nov. 16, 1946

Immediate cause of death: Coma — Duration: 15 days

Due to: Cerebral apoplexy — 2 mo.

Due to: Arterio-Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer, M.D.
Address 3300 N. Charles Date signed 11/18/46

X

G15708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G15708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Cedardale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Cedardale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Eidman

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	29 26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Eidman
13. Birthplace Germany

MOTHER
14. Maiden Name Katie Sauer
15. Birthplace Germany

16 (a) Informant Mrs. John T. Hazard
(b) Address 3501 Cedardale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-46 (month) (day) (year)
(c) Cemetery or crematory xxxx Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 20 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1946, at 3.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 19 46 to Nov. 18 19 46 and that I last saw h[illegible] alive on Nov. 18, 19 46.

Immediate cause of death

Carcinoma both breasts. (with metastases to lungs, liver, Duo to and skin)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. B. Friedman, M.D.
Address 1319 Eutaw St. Date signed 11/19/46.

X

G15709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15709 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3727 E Lombard, St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Nil
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3727 E Lombard, St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT E. CLASING

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Gertrude (Neal)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/88

8. AGE: Years	Months	Days	If less than one day
58	4	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Cabinetmaker
11. Industry or business John H Geis

FATHER
12. Name Frederick Clasing
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Worth
15. Birthplace Germany

16 (a) Informant Gertrude Clasing
(b) Address 3727 E Lombard St.

17 (a) Burial (b) Date thereof 11-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave.

18 (a) Funeral director Lilly & Zacher
(b) Address 423 S Wolfe St

19 NOV 20 1946 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-46 19 , at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31-46 19 , to 11-18-46 19 , and that I last saw h alive on 11-18-1946

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Johnston Jennings M.D.
M. D.
Address 23 W Lanvale St Date signed 11-20-46

X

15710 BALTIMORE CITY HEALTH DEPARTMENT C15710
CERTIFICATE OF DEATH 170c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Layton Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1905

8. AGE: Years 40 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank Harrison
13. Birthplace Maryland

MOTHER 14. Maiden Name Frances Strems
15. Birthplace Maryland

16 (a) Informant Frances Jones
(b) Address 111 Laurens Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Meg. H. Nelson
(b) Address 1703 Pressman St

NOV 20 1946 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1946, at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured heart, Crushed chest, Crushed pelvis,

Due to

Other Conditions Multiple fractures and contusions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-18-46 at 7:15 a. M. 4/2
(b) Where did injury occur? Greene & Saratoga Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by truck, skull fractured

23. Signature Howard J. Madden M.D. Medical Examiner.

Date signed 11-19-46

VS 191

G15711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G15711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE.
(c) Hospital or institution:
CONVALESCENCE HOME.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 YEARS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 HARFORD AVE (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE METZGER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

(b) Name of husband or wife — — —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31 - 1860

8. AGE: Years	Months	Days	If less than one day
86	9	19	hr. min.

9. Birthplace Balto- Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George F. Metzger
13. Birthplace Germany

MOTHER
14. Maiden Name Eva M. Zacheleir
15. Birthplace Germany

16 (a) Informant Miss Margaret Leonard
(b) Address 1603 Normal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by local registrar) NOV 20 1946 (b) Huntington Williams, M.D.

VS 350

MEDICAL CERTIFICATION P

20. DATE OF DEATH NOVEMBER 19 1946, at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 1 1946, to NOV. 19 1946 and that I last saw h er alive on NOV 19 1946.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS NOV 1 1946	
Due to ARTERIOR SCLEROSIS	1946
Due to SENILITY.	
Other Conditions NONE	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operations: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas O Blanton
3013 ST PAUL STREET NOVEMBER 19 1946
Address Date signed

G15712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G15712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2438 N. Howard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2438 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Stokes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Married

6 (b) Name of husband or wife Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-8-1882

8. AGE: Years	Months	Days	If less than one day
64	4	10	hr. min.

9. Birthplace Lunenburg Co Va
(Town, county, and state)

10. Usual Occupation Watchman.

11. Industry or business

FATHER
12. Name Harry Stokes.
13. Birthplace Lunenburg Co. Virginia

MOTHER
14. Maiden Name Frances Solmon.
15. Birthplace Lunenburg Co. Virginia

16 (a) Informant Ruth Stokes.
(b) Address 2438 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1946
(month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-46 19[illegible], at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1946 to Nov. 18 1946, and that I last saw him alive on 11-14-46 19

Immediate cause of death Hypostatic Congestion Broncho Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Adams, M. D.
Address 238 N Carey St Date signed 11-20-46

X

G15713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1122a

G15713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 N. Carey St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Neal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	M

6 (b) Name of husband or wife Laura Neal
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1897

8. AGE: Years	Months	Days	If less than one day
49	10	4	hr. min.

9. Birthplace Balt. Balt. Md.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

MOTHER / FATHER
12. Name Robt. Neal
13. Birthplace Md.
14. Maiden Name Betty Young
15. Birthplace Va

16 (a) Informant Robt. Neal
(b) Address 1236 N Carey St

17 (a) Burial (b) Date thereof Nov 21, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18 1946 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1946 to Nov 18 1946 and that I last saw him alive on Nov 17 1946.

Immediate cause of death	Duration
Resp Failure	1 wk
Toxemia	
Due to Intestinal Obstruction	2 wk
Due to Incarcerated Hernia	Sup.
Other Conditions Essential Hyper.	

(Include pregnancy within 3 months of death)
Date of operation 10-26-46 & 11-9-46
Major findings of operation: Incarcerated L. inguinal hernia & Intest Obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Thomas Lithenz M. D.
Address Mercy Hosp Date signed 11-18-46

Huntington Williams, M.D.

X

G15714 BALTIMORE CITY HEALTH DEPARTMENT G15714
CERTIFICATE OF DEATH 93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Henry Lee.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widower.

6 (b) Name of husband or wife Marie Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 — 10 — 1888

8. AGE: Years	Months	Days	If less than one day
58	9 2	9	hr. min.

9. Birthplace Lancaster County, Va.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name James Lee.
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Thomas.
15. Birthplace Virginia.

16 (a) Informant John L. Lee.
(b) Address 917 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Kilmarnock Virginia
Location

18 (a) Funeral director Mrs Katie C. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Register

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 19 46 at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 19 to 11/19 19 46; and that I last saw h alive on 11/17 19 46.

Immediate cause of death
(a) Coronary Thrombosis
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
3d

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Williams, M.D.
Address 4 N. John St Date signed 11-20-46

VS 150

G15715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G15715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 Radnor Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Radnor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. TAYLOR

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie E. Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1872

8. AGE: Years 74 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace Cecilton, Md.
(Town, county, and state)

10. Usual Occupation Supt.

11. Industry or business G. W. Schoehall (Realtor)

FATHER
12. Name John W. Taylor
13. Birthplace Cecil Co., Md.

MOTHER
14. Maiden Name Laura Hall
15 Birthplace Cecil Co., Md.

16 (a) Informant Mrs. Miriam Burke
(b) Address 525 Radnor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Cecilton Cem.
Location Cecilton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Signature of Registrar

NOV 20 1946

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1946, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1946 to 11-18 1946, and that I last saw h/M alive on 11-18 1946

Immediate cause of death: Coronary Occlusion. — Duration: 2 day

Due to: Coronary Arterio sclerosis ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Anthony F. Lorenzo M.D.

Address 5217 York Rd. Date signed 11/19/46

X

G15716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G15716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 St. Paul Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Mary Beaver Anderson

3 (b) If veteran, name war	3 (c) Social Security Account No.	
None	None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Gustav A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9. 1872

8. AGE: Years	Months	Days	If less than one day
74	2	11	hr. min.

9. Birthplace Waynesboro Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George B. Beaver
13. Birthplace Waynesboro, Pa.

MOTHER
14. Maiden Name Anna Walker
15 Birthplace Waynesboro, Pa.

16 (a) Informant Mr. G. C. A. Anderson
(b) Address 502 Woodlawn Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/20/46 (month) (day) (year)
(c) Cemetery or crematory
Location Waynesboro, Pa.

18 (a) Funeral director Walter Y. Grove
(b) Address 27 S. Church St. Waynesboro, Pa.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/ 1946, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1945, to Nov. 20, 1946, and that I last saw her alive on Nov. 20 1946.

Immediate cause of death Angina pectoris 2 coronary occlusion — Duration 2 hrs

Due to Uremia sclerosis

Due to

Other Conditions Rheumatic heart disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Sherman M. D.
Address 241 St Paul St. Date signed 11/20/46.

X

4-B15717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. 015717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 E. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Teufel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie Teufel
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 1-22-73

8. AGE: Years	Months	Days	If less than one day
73	9	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Teufel
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Germany

16 (a) Informant Nurse
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave
18 (a) Funeral director C. Meily Sons
(b) Address 2437 E. Oliver St
19 (a) Died on the above-named date (b) Buried by Huntington Williams Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1946, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946, to 11-19 1946 and that I last saw h. alive on 11-19 1946.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerosis with myocardial degeneration

Due to

Other Conditions Benign Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation Nov. 6 1946

Major findings of operations Prostatectomy

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Hollowell M. D.
Address J. H. H. Date signed 11-20-46

VS 150

G15718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G15718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution:
The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 St Paul Balt. #18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Malinda Hungerford

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-06

8. AGE: Years	Months	Days	If less than one day
40	9	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home Nurse
11. Industry or business

FATHER
12. Name William Hungerford
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Pardos
15. Birthplace Maryland

16 (a) Informant Mrs. Mildred Dowell
(b) Address St. Leonards, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Lusby, Md

18 (a) Funeral director A. O. Weakness & Son
(b) Address Mutual, Md

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 20 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1946 at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1946 to Nov 19 1946, and that I last saw h.e.r. alive on Nov 19 1946

Immediate cause of death Shock — Duration 28 hours

Due to Retroperitoneal hemorrhage

Due to

Other Conditions Cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation 11-9-46

Major findings of operation: Cholelithiasis

of autopsy: Retroperitoneal hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Winston Trumbo, Jr. M. D.
Address Bayview Mem. Hospital Date signed 11-19-46

G15719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 122 G15719

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Marley Heights, Glen Burnie, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Marley Neck Rd. & 1st ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Fred Laging

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of ~~husband~~ or wife Marie B. (nee Vlk)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1893

8. AGE: Years	Months	Days	If less than one day
53 yrs.	8	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Md. Drydock

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Marie B. Laging - wife
(b) Address Marley Neck Rd. & 1st Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Glen Haven Mem. Park Cem.
Location Gov. Ritchie Highway.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison St.

19 (1943) Date rec'd by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Nov 1946, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Nov 1946, to 17 Nov 1946, and that I last saw him alive on 17 Nov 1946.

Immediate cause of death: General Peritonitis — Duration: 1½ days
Due to: Perforating diverticulitis of Sigmoid colon. — 1½ days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 17 Nov 46
Major findings of operation: General Peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Bell M. D.
Address West Balto Gen Hosp Date signed 17 Nov '46

VS 150

G15720 BALTIMORE CITY HEALTH DEPARTMENT G15720
CERTIFICATE OF DEATH 95c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. East Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN Victor MACCIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 59-902-956

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Victoria (nee Skodman)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1894

8. AGE: Years	Months	Days	If less than one day
52	8	23	hr. min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation
11. Industry or business Sparrows Point

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Victoria Maccis - wife
(b) Address 409 N. East Ave.

17 (a) Burial (b) Date thereof 11/2../46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) 1946 (b) Huntington Williamsburg
(Date when registered) (Local reg. district)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1946, at 7.05 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Left cerebral hemorrhage
Due to
Other Conditions Hypertrophy of heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/19/46

VS 151

G15721 404986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

G15721 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Maderia St (If rural give location)
(e) Citizen of foreign country? TR (Yes or No)
If yes, name country

3 (a) FULL NAME Herminia (Hermina) Hacker
3 (b) If veteran, name war:
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	married

6 (b) Name of husband or wife Martin Hacker
6 (c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) 1-30-93

8. AGE: Years	Months	Days	If less than one day
53	9	20	hr. min.

9. Birthplace Europe - Austria (Town, county, and state)
10. Usual Occupation Housewife ?
11. Industry or business

FATHER
12. Name Joseph Lojik ?
13. Birthplace Czechoslovakia ?

MOTHER
14. Maiden Name Marie Cermak ?
15. Birthplace Czechoslovakia ?

16 (a) Informant Husband
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November - 19 - 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16- 1946 to 11-19- 1946 and that I last saw her alive on 11-19- 1946

Immediate cause of death	Duration
Cerebral hemorrhage	72 hrs.
Due to Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Wagley M. D.
Address Johns Hopkins Hospital Date signed 11-19-46

VS 150

G15722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G15722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 Leverton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Leverton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Jane DeGraff

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George W. DeGraff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1863

8. AGE: Years	Months	Days	If less than one day
83	9	5	hr. min.

9. Birthplace Poughkeepsie, N.Y.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name David Myers
13. Birthplace New York

MOTHER
14. Maiden Name —
15. Birthplace New York

16 (a) Informant George E. DeGraff
(b) Address 3210 Leverton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memo. Park.
Location Parkville, Md.
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

20 1946 (b) —
(Date rec'd by registrar) Thurlington Williams, Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 19, 1946 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Nov 19 1946 and that I last saw alive on Nov 18 1946

Immediate cause of death	Duration
(a) Acute Cardiac Failure	1 day
Due to (b) Arteriosclerotic Heart Disease	2 yrs.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413 E. Monument St. Date signed 11/20/46

VS 150

G15723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G15723 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 N Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 N Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James C Richards
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-18-9797

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2 1885

8. AGE: Years	Months	Days	If less than one day
61	-	17/16	hr. min.

9. Birthplace Balto (Town, county and state)
10. Usual Occupation Cleaner Tipper
11. Industry or business

FATHER
12. Name Edward P Richards
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Conroy
15. Birthplace Md

16 (a) Informant Mrs Mary Mc Comas
(b) Address 1233 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Welch Funeral Home
(b) Address 2008 Orleans St

19 (a) Date received by Registrar Nov 19 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1946 at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1946 to Nov 18 1946, and that I last saw h alive on Nov 17 1946.

Immediate cause of death Gastric Ulcer
and Secondary Anemia
Antecedent Hypostasis and
General Arteriosclerosis

Duration
Months
3 yrs 6

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert Cruberg M. D.
Address 5052 North Ave Date signed Nov 19/46

VS 150

G15721 BALTIMORE CITY HEALTH DEPARTMENT G15721
CERTIFICATE OF DEATH ✓ 61 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Schreiner Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Eugenia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Stuart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 8. 1876

8. AGE: Years	Months	Days	If less than one day
70	8	10	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John B. Stuart
13. Birthplace Md

MOTHER 14. Maiden Name Anna Wilson
15. Birthplace Md.

16 (a) Informant David Stuart
(b) Address Ferndale, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Mitzel
(b) Address 4101 Edmondson Ave.

19 (a) NOV 20 1946 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1938 to 11-18 1946 and that I last saw h[illegible] alive on 11-18 1946

Immediate cause of death: Acute Gastro Enteritis
Generalized Arteriosclerosis
Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation

of autopsy: None

Duration
8 [illegible]
? [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Coleman, M.D.
Address 1201 Eyler Road East Date signed 11-19-46

VS 150

G15725 W1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1190

G15725 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Elkins Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David H Tolson

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1946

8. AGE: Years | Months: 3 | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name James E Tolson
13. Birthplace Baltimore Maryland

MOTHER — 14. Maiden Name Edna Jones
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs James E Tolson
(b) Address 1619 Elkins Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Road

18 (a) Funeral director Williams Leach Inc
(b) Address 1317 E Pratt Street

19 (a) NOV 21 1946 (Date rec'd by registrar) (b) Registrar Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1946, at 7 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1946, to Nov 20 1946, and that I last saw him alive on Nov 20 1946.

Immediate cause of death: Circulatory failure — Duration

Due to: Otitis Media

Due to: Chronic Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Swindell M.D.
Address 213 Light St Date signed Nov 25 46

Herbert Swindell

5726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45a

Registered No. G15726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 99 days
(e) Length of stay in Baltimore (yrs., mos., or days) 99 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Long Island, Bayshore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 78 Redmond Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eifert, John Casper

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Duffy Eifert
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1883

8. AGE: Years 63 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Eddyville, NY (Town, county, and state)
10. Usual Occupation Master
11. Industry or business Seafarer

FATHER
12. Name John Eifert
13. Birthplace NY

MOTHER
14. Maiden Name Catherine Wagner
15. Birthplace NY

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 11/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Patricks
Location Bay Shore L.I. N.Y.

18 (a) Funeral director Wilhom Conlon
(b) Address 1219 Lt Court

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 21 1946

VS 150

Christopher Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1946, at 2:10 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 13 1946 to Nov. 20 1946, and that I last saw him alive on Nov. 20 1946.

Immediate cause of death: Metastic lesion of cervical nodes bilaterally — Duration:
Due to: Squamous cell carcinoma
Due to: of Lip.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Kelson Jr. M. D.
Address U.S. Marine Hosp. Date signed 11/22/46

X

2-Trans-
1-Permit G157127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G157127 Registered No. 477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **Wyman Pk. Drive & 31st St.**
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **45 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **45 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **NJ** (b) County
(c) City or town **Pennsville**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **68 W. Chestnut St.**
(If rural give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3 (a) FULL NAME **Smith, Charles Norman**

3 (b) If veteran, name war: ?
3 (c) Social Security Account No.: ?
4. Sex: **M**
5. Color or race: **W**
6 (a) Single, married, widowed, or divorced: **Married**
6 (b) Name of husband or wife: **Annie Kepheard Smith**
6 (c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): **Dec. 31, 1885**
8. AGE: Years **60** Months **10** Days **18** If less than one day: hr. min.
9. Birthplace: **Phila, Pa.** (Town, county, and state)
10. Usual Occupation: **Deckhand**
11. Industry or business: **Seafarer**

FATHER
12. Name: **Wm. Smith**
13. Birthplace: **Phila, Pa.**

MOTHER
14. Maiden Name: **Rose Murphy**
15. Birthplace: **?**

16 (a) Informant: **Records**
(b) Address: **US Marine Hospital**

17 (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Nov 21-1946** (month) (day) (year)
(c) Cemetery or crematory **Govans Presbyterian** Location **Baltimore Maryland**
18 (a) Funeral [illegible] **Ellsworth Avenue** [illegible] **Liberty Heights Ave.**
19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

NOV 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: **Nov. 18** 1946 **8:25** P M

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 4** 1946 to **Nov. 18** 1946, and that I last saw h**im** alive on **Nov. 18** 1946.

Immediate cause of death: **Epidermoid carcinoma of right lung with visceral metastasis** — Duration: **UNKNOWN**
Due to
Due to
Other Conditions: **Bronchopneumonia, bilateral** — Duration: **FEW DAYS**
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: **As above**

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: **John L. Wilson**
Address **Clinical Director** Date signed **11/20/46** M. D.

VS 150

X

G15728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1184

G15728 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
City morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Wayne Truman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 30-1933

8. AGE: Years	Months	Days	If less than one day
13	67	19	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation — School boy
11. Industry or business

MOTHER | FATHER
12. Name Richard K. Truman
13. Birthplace Salisbury Md.
14. Maiden Name Harriet E. Alexander
15. Birthplace York - Pa.

16 (a) Informant Mother
(b) Address 2741 Prospect St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21-46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Balto, Md.

18 (a) Funeral director Harry N. Aymadst
(b) Address 1204 Ridgewood Ave.

19 (a) Filed Nov 21 1946 (b) Registrar

VS 191

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1946, at 3 20 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) ~~by said Autopsy~~, Inspection or ~~Inquiry~~, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Undetermined

Due to Post-mortem decomposition of extremities.

Other Conditions Practically a skeleton

(Include pregnancy within 3 months of death)

22. If an external cause was probably primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-?-46 at ? 15/9 M.
(b) Where did injury occur? Wood - Gwynn Falls Rd. near Mt. Holly St.
(c) Did injury occur at home, on farm, industrial place, in public place? Unknown While at work? ?
(d) Means of injury Possibly firearms

23. Signature Howard J. Mahoney, M.D.
Medical Examiner.
Date signed 11-20-46

G15729 G15729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levendale Home
(c) Hospital or institution: Belvedere & Greengspring ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH SHEAR

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Late Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Jack Shear
(b) Address 3406 Auchentorly Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 46 (Month) (Day) (Year)
(c) Cemetery or crematory Shaarei Tefilah Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Sol Kurzman Bur
(b) Address 1124-26 W North ave

19 (a) NOV 21 1946 (Date received by Registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1946, at 9:22 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1946 to 11-19 1946 and that I last saw h[illegible] alive on 11-19 1946.

Immediate cause of death Coronary occlusion — Duration

Due to —

Due to —

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Henry Wajd M. D.
Address Levindale Home Date signed 11-19-46

X

G15730 **BALTIMORE CITY HEALTH DEPARTMENT** G15730
CERTIFICATE OF DEATH 167 **Registered No.**

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 North Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanie Lee Means

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife George
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1920

8. AGE: Years	Months	Days	If less than one day
26	9	11	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Wade Means
13. Birthplace South Carolina

MOTHER
14. Maiden Name Maggie Roseborough
15. Birthplace South Carolina

16 (a) Informant Wade Means
(b) Address Annapolis Road

17 (a) Burial (b) Date thereof 11-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Edmondson Ave.

19 (a) (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1946, at 2 45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of heart, pericardial hemorrhage (tamponade)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-16-46 at 9 P M.
(b) Where did injury occur? 300 blk. north Stricker St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed with sharp instrument

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 11-18-46

NOV 27 1946
VS-191 Huntington Williams, M.D.

A 5-15-19 G15731 ✓ G15731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Brendon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RASPER, JOAN — (Nuenchi)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-16-35

8. AGE: Years	Months	Days	If less than one day
10 11	11	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Flavius Rasper
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen Lang
15. Birthplace Maryland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ogozewski
(b) Address 1930 Eastern Ave.

19 (a) (b) Registrar

NOV 21 1946 Washington Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1946, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1946, to 11-19 19..; and that I last saw h alive on 11-19 1946.

Immediate cause of death: Subarachnoid Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leopold Blumberg M. D.
Address Johns Hopkins Hospital Date signed 11-19-46

X

G15732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

G15732
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U.S.Marine Hospital 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) **8days**
(e) Length of stay in Baltimore (yrs., mos., or days) **lieftime**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Maryland** (b) County **- ---**
City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3006 Elgin Avenue**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **----**

3 (a) FULL NAME **Parks, Edwin Robert**

3 (b) If veteran, name war **WW#1**

3 (c) Social Security Account No. **220-09-4698**

4. Sex **m**

5. Color or race **wh**

6 (a) Single, married, widowed, or divorced **Mar.**

6 (b) Name of ~~husband~~ or wife **Gertrude Parks (nee Fischer)**

6 (c) If alive, give age **?** years

7. Birth date of deceased (mo., day, yr.) **July 16,1896**

8. AGE: Years **50** Months **4** Days **4** If less than one day hr. min.

9. Birthplace **Baltimore, Maryland** (Town, county, and state)

10. Usual Occupation **Inspector-Glen L.Martin**

11. Industry or business **Veteran-**

FATHER
12. Name **Parks, William D.**
13. Birthplace **Maryland**

MOTHER
14. Maiden Name **~~Elizabeth Anne~~ Anna Williams**
15. Birthplace **Maryland**

16 (a) Informant **Records**
(b) Address **U.S.Marine Hospital**

17 (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11/23/46** (month) (day) (year)
(c) Cemetery or crematory **Balto. National Cem.**
Location **Balto., Md.**

18 (a) Funeral director **WM. J. TICKNER & SONS**
(b) Address **Balto., Md.**

19 (a) (b)
Registrar

NOV 21 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov. 20** 1946, at **2:56 P.M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Nov.12** 19**46** to **Nov.20** 19**46**, and that I last saw **him** alive on **Nov.20** 19**46**.

Immediate cause of death **CARCINOMA OF LEFT LUNG**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **As above**

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature **W.H. Nelson Jr.** M. D.
Address **U.S. Marine Hosp.** Date signed **11/20/46**

G15733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WARREN L. LITTLE

3 (b) If veteran, name war: ?

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Anna M. Little
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1868

8. AGE: Years	Months	Days	If less than one day
78	6	21	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Agent
11. Industry or business B. C. A. Steamship Lines

FATHER
12. Name P. John Little
13. Birthplace Maryland

MOTHER
14. Maiden Name Sophia Garmhausen
15 Birthplace Md.

16 (a) Informant: Mrs. Anna M. Little
(b) Address 1610 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1946 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to Nov. 1946.
and that I last saw him alive on Nov. 12 1946.

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2924 Brighton St. Date signed 11-18-46

V S 170 NOV 21 1946 Huntington Williams, M.D.

X

G15731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G15734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Cedar Dale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 3602 Cedardale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Sinclair

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife James F.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1872

8. AGE: Years 74 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business —

FATHER
12. Name John Wade
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rose Stritmann
15. Birthplace Balto Md

16 (a) Informant Mrs John A. Finn
(b) Address 3602 Cedardale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Md Co.

18 (a) Funeral director Flynn & Heyman
(b) Address 1016 Light St

19 (a) Filed NOV 21 1946 (b) Registrar
(Date filed by registrar)
Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18. 1946 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1946 to Nov 18 1946 and that I last saw him alive on Nov 17. 1946.

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Due to Myocarditis	8 mos.
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 136 E. Ost Ave. Date signed 11/19/46

G15735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

G15735 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto Gen. Hosp. 19
(d) Length of stay in hospital or inst. (yrs., ~~mos., or~~ days) 2
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 S Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie H Wiebking

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5 1885

8. AGE: Years	Months	Days	If less than one day
61	7 8	15	hr. min.

9. Birthplace Balto Md (Town, county, state or foreign country)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Thomas Johnson

13. Birthplace Balto.

MOTHER 14. Maiden Name Anna C Gatts

15. Birthplace Balto.

16 (a) Informant William H Wiebking

(b) Address 408 S Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1946 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director Frederick A Cole

(b) Address 2008 W Lombard St

NOV 21 1946 (Date received by Registrar) Wm. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1946 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1946 to 11/20 1946 and that I last saw he alive on 11/20 1946

Immediate cause of death: Aspiration Collapse 4 shock — Duration

Due to Major operation for strangulated hernia

Other significant conditions: Arteriosclerosis Hypertension C.V.D. +

(Include pregnancy within 3 months of death)

Date of operation 11/19/46

Major findings of operation: Strangulated umbilical hernia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J C Carrickhoff Jr

Address So Balto Gen Hosp Date signed 11/20/46

VS 150

G15736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G15736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mount Holland Ave
(c) Hospital or institution: Lewis Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Cross

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-12-9553

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	widowed

6. (b) Name of husband or wife Virginia B. Cross
6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 30, 1901

8. AGE: Years	Months	Days	If less than one day
45	5	1920	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Edward Cross
13. Birthplace New York City

MOTHER
14. Maiden Name Margaret McKeever
15. Birthplace Baltimore

16 (a) Informant Mrs. Virginia Cross
(b) Address 1136 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1946 (mo.) (day) (yr.)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St. Huntington Woods, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1946 at 1:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1946 to 11/19 1946 and that I last saw h[illegible] alive on 11/19 1946.

Immediate cause of death Uremia, probably due to

Duration

Due to Uremia, chronic nephritis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation 11/14/46

Major findings of operation: Carcinoma kidney

of autopsy: Bronchopneumonia, chronic nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis B. Tankin
Address Lewis Hospital Date signed 11/19/46 M. D.

VS-150 NOV 21 1946

LOUIS - TANKIN X

G15737 ✓ G15737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 98

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 1 + 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Hoat St. (24)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Lardner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1868

8. AGE: Years	Months	Days	If less than one day
78	9	7	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name deceased
13. Birthplace

MOTHER
14. Maiden Name deceased
15. Birthplace

16 (a) Informant Mr. Howard Lardner
(b) Address 3304 Hoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director Lilly + Zitkus
(b) Address [illegible]

19 (a) (Date rec'd by reg'r) Huntington Williams M.D. (Registrar)

VS 300 NOV 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1946, at 11 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1946, to 11-18 1946, and that I last saw h[illegible] alive on 11-18 1946.

Immediate cause of death	Duration
Cardiac failure	
Arteriosclerosis	
Embolic left leg	
Due to Dry gangrene	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 11/18/46

X

738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G15738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 Harlen Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH BRISCOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1869

8. AGE: Years 77 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Prisella Johnson
15. Birthplace Md.

16 (a) Informant Mrs. Mary Brooks
(b) Address 505 Caroline Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) NOV 21 1946 (Date received by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1946 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5-46 to 11-19-46, and that I last saw h[illegible] alive on 11-19-46.

Immediate cause of death [illegible] Duration

Due to [illegible] 4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date 11-23-46

VS 180

5739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. G15739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 Bradley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Bradley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM CRISS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Sarah Criss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1890

8. AGE: Years	Months	Days	If less than one day
56	4	9	hr. min.

9. Birthplace Littleton, N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Criss
13. Birthplace N. C.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace N. C.

16 (a) Informant Mrs. Sarah Criss
(b) Address 743 Bradley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.
18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.
(c) NOV 21 1946 Huntington Williams M.T.
(Date received by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH November 19, 1946 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1946 to 11-19 1946 and that I last saw her alive on 11-18 1946

Immediate cause of death Carcinoma Prostate — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. N. Hatch M.D.
Address 1 W 39 St Date signed 11/19/46

VS 150

X

G15710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G15710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 N. COLLINGTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. COLLINGTON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT FRIEDMAN

3 (b) If veteran, name war C

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife REBECCA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER 12. Name HARRY
13. Birthplace RUSSIA

MOTHER 14. Maiden Name FRIEDA
15. Birthplace RUSSIA

16 (a) Informant HARRY FRIEDMAN - SON
(b) Address 2709 GELEG TER.

17 (a) BURIAL (b) Date thereof 11-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila Rd + Ham. Ave

18 (a) Funeral director VASIL LEWIS INC
(b) Address 1439 E. BALTO ST

19 (a) (Date rec'd by Registrar) NOV 21 1946 Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-46 19 at 5:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 19 45 to Nov 21 19 46 and that I last saw [illegible] alive on Nov 20 19 46

Immediate cause of death Carcinoma of stomach — Duration 1 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon
Address 129 S Bway Date signed 11/21/46

VS 150

G15711 ✓ G15711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 N. Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna B. Trautner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fred. G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 3-1886

8. AGE: Years 60 | Months 2 | Days 17 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state or foreign country)

10. Usual Occupation: Housewife

11. Industry or business: "

FATHER — 12. Name: ? "
FATHER — 13. Birthplace: ? Germany

MOTHER — 14. Maiden Name: ? Finf
MOTHER — 15. Birthplace: Germany

16 (a) Informant: Fred. G. Trautner
(b) Address: 1 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Taylor Ave

18 (a) Funeral director: John J. McGraw
(b) Address: 3000 E. Balto St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar)

NOV 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 - 1946 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to Nov 20 1946; and that I last saw her alive on Nov 19 1946.

Immediate cause of death: Carcinomatosis — Duration: Jan 1/46
Carcinoma - nasopharynx (left)
Due to:
Due to:
Other Conditions: Hemi plegia (right) 11/15/46
Extension of Carcinoma to brain
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Krumrein
Address 722 N. Kenwood Ave Date signed 11/20/46 M.D.

×

G15712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G15712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 2
(e) Length of stay in Baltimore (yrs., mos., or days) 56

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Roanoke Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE ISABELLE CLARKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	S

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	3	___ hr. ___ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Ray S. Clarke
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Isabelle Kane
15. Birthplace Maryland

16 (a) Informant Hospital Record
(b) Address 33rd & Calvert Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46

(c) Cemetery or crematory Maryland Park
Location Gayla. Md

18 (a) Funeral director John A. Wilson
(b) Address 300 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

NOV 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1946, at 6:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1946 to Nov 20 1946, and that I last saw he alive on Nov 20 1946.

Immediate cause of death	Duration
Rheumatic heart disease	
Due to Old, inactive	
Due to	
Other Conditions Bilateral basal pneumonia	
(Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford W. Kilpatrick Jr. M.D.
Address Union Mem. Hosp. Date signed 11/20/46

95c

B615793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 615793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: South Baltimore Gen Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Baasman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Sarah Baasman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	4	16		

9. Birthplace Maryland (State, county, and state)
10. Usual Occupation Statistician
11. Industry or business Federal Housing

FATHER
12. Name Frank Baasman
13. Birthplace Maryland

MOTHER
14. Maiden Name Lukpeter
15. Birthplace Unknown

16 (a) Informant Mrs Laura Disney
(b) Address 2825 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 23/46 (month) (day) (year)
(c) Cemetery or crematory Mouland Park
Location Taylor Ave

18 (a) Funeral director Ellenore Robinson
(b) Address 3615-17 Chestnut Ave

NOV 21 1946
(a) (State rec'd by registrar) (b) Registrar

Lucretia Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1946 to 11-20 1946 and that I last saw him alive on 11-20 1946.

Immediate cause of death: Cerebral hemorrhage

Due to Hypertension cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Swindell MD M. D.
Address 1618 Eight St Date signed 11-20-46

VS 150

H. SWINDELL X

G15744 — 404072 — G15744 Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town Towson, (If outside city or town limits, write RURAL and give town)
(d) Street No. North York Rd., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rena Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Napoleon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6th 1892

8. AGE: Years 54 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Howard Johnson
13. Birthplace Md.

MOTHER 14. Maiden Name Irene Simms
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21st 1946 (mo.) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Balto County Md.

18 (a) Funeral director Bohrer Framis & Knight
(b) Address 725 Cresgate St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1946, at 12 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6- 1946 to 11-17- 1946, and that I last saw her alive on 11-17- 1946.

Immediate cause of death Bronchopneumonia — Duration

Due to Anemia

Due to Postpartum Uterine Bleeding

Cause undetermined

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund L Dubois M. D.

Address Johns Hopkins Hospital Date signed 11-17-46

X

G15715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G15715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Hoffman
(c) Hospital or institution:
St. Joseph's Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MOLLER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Colored	

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-23-12

8. AGE: Years	Months	Days	If less than one day
34	6	27	hr. min.

9. Birthplace N. Jersey
(Town, county, and state)
10. Usual Occupation Laundress.
11. Industry or business

FATHER
12. Name Charles W. Hilton
13. Birthplace Va.

MOTHER
14. Maiden Name Bertha Stieff
15. Birthplace Va

16 (a) Informant Wm. Dudley
(b) Address 1301 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph E. Cook Jr.
(b) Address 1364 N. Central Ave

19 (a) (b)
(Signature of Registrar)
NOV 21 1946 Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1946, at 2:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1946, to Nov 20 1946, and that I last saw her alive on Oct. 21 1946.

Immediate cause of death Cardio-Resp. failure — Duration

Due to Uremia

Due to Carcinoma of cervix " " Bladder

Other Conditions Peritonitis

(Include pregnancy within 3 months of death)
Date of operation Sept. 21, 1946.
Major findings of operation Carcinoma
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry T. Wilson Jr. M. D.
Address St. Joseph's Hosp. Date signed 11/26/46

X

G15716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G15716 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2047 Penn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-18
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3903 Dolfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hyman Snyder

3 (b) If veteran, name war:
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Baila
15. Birthplace Russia

16 (a) Informant Milton Snyder
(b) Address 2047 Penn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Wilkens Ave & Rolling Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1609 E Fells St

21 1946
19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19-1946 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1946 to Nov 19 1946 and that I last saw deceased alive on Nov 14 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	15 min.
Due to " "	
Due to Coronary Thrombosis	15 min.
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Nathan Snyder M. D.
Address 17 W St Paul St Date signed Nov 19 46

VS 150

X

G15717

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

✓ G15717
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Anoka ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Anoka ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA HALPERT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and State)

10. Usual Occupation Home Work

11. Industry or business

FATHER
12. Name Adolph
13. Birthplace Austria

MOTHER
14. Maiden Name Rhandel
15. Birthplace Austria

16 (a) Informant Rae Rebenker
(b) Address 2309 Anoka Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto & Conkling St

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Balto St

NOV 21 1946 (b) Huntington Williams
(Date filed by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1946 at 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to Fractured neck
Fractured nose

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-21-46 at 9:30 A.M.
(b) Where did injury occur? 2309 Anoka ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell out of window.

23. Signature George L. Merrick M.D.
Medical Examiner
Date signed 11/21/46

X

G15718 BCH 90 58159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G15718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 3, 1946

8. AGE: Years	Months	Days	If less than one day
	1	48 17	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Gray Lloyd
13. Birthplace

MOTHER
14. Maiden Name Peggy Gundy
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-46 (month) (day) (year)
(c) Cemetery or crematory ~~Rock Creek~~ Arlington Memorial Pk
Location md

18 (a) Funeral director George B. Nelson
(b) Address 1303 Presstman St

NOV 21 1946 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1946 at 6:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1946 to Nov. 20 1946 and that I last saw him alive on Nov. 20 1946.

Immediate cause of death: anemia marked — Duration
born premature
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 11-20-46

VS 150

G15719 | BALTIMORE CITY HEALTH DEPARTMENT | G15719 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2541 St Paul St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W Mc Closky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Grace Mc Closkey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1888

8. AGE: Years 58 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Denver Colorado (Town, county, and state)

10. Usual Occupation Shipyard Worker

11. Industry or business Bethlehem Shipbldg Co

FATHER
12. Name Unknown
13. Birthplace Colorado

MOTHER
14. Maiden Name Unknown
15. Birthplace Colorado

16 (a) Informant Mrs Grace Mc Closkey
(b) Address 2541 St Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Balto Md

18 (a) Funeral director Albert L Hilbert
(b) Address 1406 N Chester St
(c) Filed 21 1946 (Date rec'd by registrar) Thurlington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1946, at 12:25 M

21. I certify that I took charge of the remains described above, held an Inq & Autop thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Exp death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelford M.D.
Medical Examiner
Date signed Nov 19 46

VS 151

5750 BALTIMORE CITY HEALTH DEPARTMENT 1084 Registered No. C75750

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Beatty ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1876

8. AGE: Years 70 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Gloucester Co. Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Temple Hyatt
13. Birthplace Gloucester Co. Va.

MOTHER
14. Maiden Name Harriett ? ? ?
15. Birthplace Gloucester

16 (a) Informant Mr. George Tolbert
(b) Address 192 N. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1691 Druid Hill Ave

19 (a) NOV 21 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1946 at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/1946 to 11/16/1946, and that I last saw him alive on 11/16/1946

Immediate cause of death: Coronary occlusion — Duration
Due to: Exposure — "
Due to: Cirrhosis of Liver — "
Other Conditions: Contributed to death

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury
23. Signature Wm. K. Bankerd M.D.
Address 526 N. Carey Street Date signed Nov. 22, 1946

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

3751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G15751 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2934 Winchester St.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2934 Winchester St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel M. Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Mary E. Yost
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1855

8. AGE: Years	Months	Days	If less than one day
91	2	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Ward
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Stanley M. Ward
(b) Address 2934 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1600 Eutaw Place

19 (a) 1 40 fc (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1946 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1946 to Nov 20 1946 and that I last saw h alive on April 11 1946

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert J. Mitchell M.D.
Address 2302 Edmondson Ave. Date signed 11/20/46

Howard J. Weaver, Md.

VS 150

D.O.A. Coroner's No. G15752

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V186a

G15752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Wilcox St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alma Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	black	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James Berry
13. Birthplace ? ? ?

MOTHER
14. Maiden Name Amelia ? ?
15. Birthplace ? ? ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/46 (month) (day) (year)
(c) Cemetery or crematory ~~Mount~~ Calvary
Location Greenville, S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Druid Hill Ave
(c) Thirty-four Williamsburg, Md.

NOV 21 1946 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1946, at 7 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on DOA. 19

Immediate cause of death Pulmonary Embolism — Duration

Due to

Due to

Other Conditions Chip fract. of ankle.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy Not performed.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Nov. 2 1946 @ 3 0 M
(c) Where did injury occur? 1011 Wilcox St Balt (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place Daughter's home While at work? No (Specify type of place)
(e) Means of injury fell striking head on floor and fell down

23. Signature [illegible] Address [illegible] Date signed 11-19-46

Howard J. Masters, M.D.

VS 150

G15753 BALTIMORE CITY HEALTH DEPARTMENT G15753
CERTIFICATE OF DEATH 83a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Myrtle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Myrtle Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Verby Sample.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Lillian C. Sample
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-1886.

8. AGE: Years	Months	Days	If less than one day
60	3 2	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Emerson Sample.
13. Birthplace Md.

MOTHER
14. Maiden Name Isabella Warfield
15. Birthplace Md.

16 (a) Informant Lillian Chester Sample
(b) Address 1122 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

NOV 21 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1946. at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 17 1946 and that I last saw h alive on Nov 17 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Percy
Address 352 George St Date signed Nov 19 46

X

G15751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G15751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 S. Charles St.
(c) Hospital or institution:
16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 1113 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence W. Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ella Dorsey
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1891

8. AGE: Years	Months	Days	If less than one day
54	10	25	hr. min.

9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Florist
11. Industry or business

FATHER
12. Name Charles J. Frank
13. Birthplace Md.

MOTHER
14. Maiden Name Christine Schwab.
15. Birthplace Md.

16 (a) Informant Mrs Ella Frank
(b) Address 1113 Poplar Grove.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md.

18 (a) Funeral director John F. Keaney Inc
(b) Address 718 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20th 1946, at 5 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1946 to Nov 20 1946.
and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary thrombosis	1 hour
Due to arteriosclerosis	
Due to	
Other Conditions Hypertension	1 year

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Muller M. D.
Address 224 Clarke Date signed X 11 20 46.

VS 100 Huntington Williams, M.D.

G15755

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G15755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 Mosher Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Kilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6. (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1884

8. AGE: Years 62 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John Kilson
13. Birthplace Maryland

MOTHER
14. Maiden Name Edna Young
15. Birthplace Maryland

16 (a) Informant Sam Parker
(b) Address 1002 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (Month) (day) (Year)
(c) Cemetery ~~or crematory~~ W. F. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Haberland
(b) Address 918 Druid Hill Ave.

19 (a) Received by [illegible] (b) Registrar [illegible]

NOV 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20, 1946 at 5-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1946 to Nov 20 1946, and that I last saw h alive on Nov 18 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 7

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury HERBERT MOSELEY

23. Signature Herbert K. Moseley Jr. M. D.
Address 2024 Madison Ave Date signed 11/20/46

VS 150

X

G15756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓18-L

G15756 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W.Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Cambria St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Stockman

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. Stockman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan.1,1867

8. AGE: Years 79 | Months 10 9 | Days 11 19 | If less than one day hr. min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name #

15. Birthplace #

16 (a) Informant: Mr.Henry Stockman

(b) Address: 222 Baltimore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov.22/46 (month) (day) (year)

(c) Cemetery or crematory: Mt.Carmel Cem.

Location: Balto. Md.

18 (a) Funeral director: Phillips Stirling Sons

(b) Address: 2024 Orleans St.

19 (a) NOV 21 1946 (b) Huntington Hillen Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov.20/46 19 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1946 to Nov 20 1946 and that I last saw h[er] alive on Nov 19 1946

Immediate cause of death	Duration
(a) Cerebral Embolism	10 days
(b) Chronic Myocarditis	10 days
Due to (c) Fracture Rt femur	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? Accident
(b) Date of occurrence 11/17/46 at 10 A M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify) While at work? No
(e) Means of injury: Fell + fractured rt femur

23. Signature: H. J. Ackerman

Address 129 S Paca Date signed 11/24/46

Howard J. Ackerman, M. D.

G15757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G15757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 N. Wolfe St.
(c) Hospital or institution: +- 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles F. Schwartz

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1870

8. AGE: Years	Months	Days	If less than one day
76	10	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Straw hat maker
11. Industry or business

FATHER
12. Name Henry Schwartz
13. Birthplace Maryland

MOTHER
14. Maiden Name Unk.
15. Birthplace

16 (a) Informant Henry Schwartz
(b) Address 2238 Cecil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St.

19 (a) Nov 21 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1946, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1946, to Nov 10 1946, and that I last saw him alive on Nov 10 1946.

Immediate cause of death: Coronary occlusion — Duration: ?
Due to: Hypertensive cardiovascular disease
Due to: Senile arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore L. Graziano M. D.
Address 2802 Harford Rd Date signed 11/20/46

X

G15758 B.C. # 64812 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G15758

CERTIFICATE OF DEATH ✓159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2556 Mace St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Died

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2556 Mace St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Child

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Cleveland Boyd
13. Birthplace Va.

MOTHER — 14. Maiden Name Minnie Coleman
15. Birthplace Va.

16 (a) Informant Minnie Coleman
(b) Address 2556 Mace St.

17 (a) Burial (b) Date thereof 11-20-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Co. Md.

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) (Date received by Local Registrar) (b) Registrar

NOV 22 1946
Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1946, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1946 to Nov. 20 1946; and that I last saw him alive on Nov 20 1946.

Immediate cause of death	Duration
(a) Premature	
Due to (b) Intra-uterine Atelectasis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar W. Northington M.D.
Address 4 S Wolfe St Date signed 11-21-46

G15759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √121

G15759 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 S. W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Payson St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Forsyth George Herbert Forsyth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1928

8. AGE: Years 18 Months 3 Days 27 If less than one day hr. min.

9. Birthplace Baltimore — Md. (Town, county, and state)

10. Usual Occupation Lathe Operator

11. Industry or business Machine Shop

FATHER
12. Name George C. Forsyth
13. Birthplace Balto.

MOTHER
14. Maiden Name Blanche
15. Birthplace

16 (a) Informant George C Forsyth
(b) Address 621 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H Weitzel
(b) Address 4101 Edmondson Ave

19 (Date filed by registrar) 21 1946 Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17/1946, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1946 to 11/17 1946, and that I last saw him alive on 11/17 1946.

Immediate cause of death Pulmonary embolism - acute - massive

Due to

Due to

Other Conditions acute appendicitis ruptured 11 days prior to death

(Include pregnancy within 3 months of death)

Date of operation 11/10/46

Major findings of operation: acute appendicitis

of autopsy: Pulmonary embolism

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Ward M. D.

Address Bon Secours Hosp Date signed 11/17/46

VS 150

G15760 BALTIMORE CITY HEALTH DEPARTMENT G15760
CERTIFICATE OF DEATH 1/8 3a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Powhatan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Powhatan Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON WERTHEIMER, Sr.

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rosalind G. Wertheimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1883.

8. AGE: Years 62 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace New York. (Town, county, and state)

10. Usual Occupation Cigar Mnfgr.

11. Industry or business

FATHER
12. Name Isaac Wertheimer,
13. Birthplace New York.

MOTHER
14. Maiden Name Hattie Silberstein,
15. Birthplace Germany.

16 (a) Informant Mr. Leonard Wertheimer,
(b) Address 930 Brooks Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) 21 Nov 1946 1902 Eutaw Place, Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th. 1946 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14-1945 to 11-20 1946; that I last saw h[illegible] alive on 11-20 1946.

Immediate cause of death — Duration
Cerebral hemorrhage — 6 days
Due to Hypertension — 6 yrs.
Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Leonard Cohen M. D.
Address Marlborough Apts. Date signed

VS 150

G15761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G15761 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 Brooks Lane.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Brooks Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE HEINEMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva M. Heineman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1879.

8. AGE: Years 67 | Months 1 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clothing Mnfgr.
11. Industry or business

FATHER
12. Name Marcus Heineman,
13. Birthplace Germany.

MOTHER
14. Maiden Name Bettie Sonneborn,
15. Birthplace Cumberland, Md.

16 (a) Informant Mrs. E. M. Heineman,
(b) Address 925 Brooks Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.22.46. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Burial Commission of Balto
(b) Address 1902 Eutaw Place,

19 (a) [illegible] 1946 (b) [illegible] Burlington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1946, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to Nov 21 1946, and that I last saw him alive on Nov 20 1946

Immediate cause of death: Congestive Heart Failure: Symptoms — Duration: 15 mos

Due to Arteriosclerotic Heart disease: symptoms — 3 years

Due to Coronary artery sclerosis: Generalized arteriosclerosis: symptoms — 3 years

Other Conditions

(Include pregnancy within 3 months of death).

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed

VS 150

X

G15762

CHK-99319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15762 Registered No. 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9- 2-
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 McTeague Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Etta Fuller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10-1877

8. AGE: Years	Months	Days	If less than one day
69	4	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

PARENTS
12. Name Bendix Shorter (D)
13. Birthplace Maryland

PARENTS
14. Maiden Name Mary Proctor (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22 1946 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Wallace
(b) Address 222 N. Schroeder St.

19 (a) (Signature) (b) Registrar
Huntington-Hillsdale, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 19 46 at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 19 46 to Nov. 18 1946, and that I last saw her alive on Nov. 18 19 46

Immediate cause of death: Heart failure — Duration
Due to H A S C V Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Examination

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W Doyle Walker M. D.
Address BCH Date signed 11/25/46

VS 130

93

G-45763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G45763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 N. Howard st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Howard st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret V. Blake

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph P. Blake

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1900

8. AGE: Years 46 | Months 10 | Days 14 | If less than one day: hr. min.

9. Birthplace Pittsburgh Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Patrick Costello

13. Birthplace Pa.

MOTHER 14. Maiden Name Margaret (Unknown)

15. Birthplace Pa.

16 (a) Informant: Robert Blake

(b) Address 702 N. Howard St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/22/46 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St Paul St.

19 (a) NOV 22 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20th 1946, at 2:19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Nov 20 1946 and that I last saw h Lt alive on Nov 20 1946.

Immediate cause of death: Bronchopneumonia (Hypostatic)

Due to: Carcinoma of Stomach

Due to: Carcinoma of Pancreas (?)

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town.) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward H. Hessman, M.D.

Address 4031 Falls Rd. Date signed 11/20/46

VS 150

G15761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G15761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 W Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fallon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24 1861

8. AGE: Years	Months	Days	If less than one day
84	4	29	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Stuffing Cork
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Emma Long
(b) Address 516 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1946 (month) (day) (year)
(c) Cemetery or crematory London
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1219 W Lombard St

19 (a) NOV 22 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1946 to Nov 20 1946 and that I last saw h alive on Nov 20 1946.

Immediate cause of death: Carcinoma of Stomach — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Fayette St Date signed Nov 24 46

VS 150

G15765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1 50

Registered No. G15765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Cardiff
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Howard P. Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Howard P. Fowler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 89

8. AGE: Years	Months	Days	If less than one day
56	2	21	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Heaps
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Boyter
15. Birthplace Maryland

16 (a) Informant Hospital record
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-46 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location York Co. Penna.

18 (a) Funeral director Hubert P. Warburton
(b) Address Delta, Penna.

19 (a) (b) Registrar

NOV 22 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1946; at 5:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1946, to Nov 21 1946, and that I last saw h.21 alive on Nov 21 1946.

Immediate cause of death Metastatic carcinoma. — Duration

Due to Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin O. Henderson M. D.
Address Union Memorial Hosp. Date signed 11-24-46

X

G15786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. G15786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Jefferson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Jefferson St., (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Roberts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or ~~wife~~ Asa Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1860

8. AGE: Years	Months	Days	If less than one day
86 yrs.	5	30	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name McFarland
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Joseph S. Roberts - nephew
(b) Address 2705 Orleans Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Person acting as registrar) (b) Huntington Williams, M.D. Registrar

NOV 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1946, at 11 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1946 to Nov. 19 1946, and that I last saw h ~~er~~ alive on Nov. 19 1946

Immediate cause of death	Duration
Hypertensive cardiovascular renal disease.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J Johnson M. D.
Address 701 N. Linwood Ave. Date signed 11/20/46

X

G15787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106B

Registered No. G15787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Whitridge Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Whitridge Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMILIE ELIZABETH LENZ

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry George Lenz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1868

8. AGE: Years 78 | Months 5 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ludwig Unger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Edith M. Lewis, daughter
(b) Address 402 Whitridge Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Wilson M.D.
NOV 22 1946

V S 106

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 19 46 at 8:25AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946, to Nov 21 1946, and that I last saw h alive on Nov 20 1946

Immediate cause of death	Duration
Terminal Bronchopneumonia	24 hrs.
Due to Generalized Arteriosclerosis.	?
Due to	
Other Conditions Chronic Prostatitis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel [illegible]
Address 1761 E Mon Ave Date signed 11/22/46 M. D.

X

G157G8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G157G8 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5505 Wesley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Wesley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Ino.

3 (a) FULL NAME Anton Stitz

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	White	married

6 (b) Name of husband or wife Mary Stitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9- 1897

8. AGE: Years	Months	Days	If less than one day
59	6	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House Painter
11. Industry or business Retired

FATHER
12. Name Adam Stitz
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wright
15. Birthplace Germany

16 (a) Informant Mrs. Mary Stitz
(b) Address 5505 Wesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Pk.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date filed by Registrar) NOV 27 1946 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21- 1946, at 9:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1943 to Nov. 21 1946, and that I last saw h.. alive on Nov. 21 1946.

Immediate cause of death	Duration
Coronary Thrombosis	11/21/46
Due to	
Due to Chr. Myocarditis	1943
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul E. Brown M.D.
Address 16310 North Ave Date signed 11-26-46

VS 150

G15769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B45769 Registered No.

✓ 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DUKELAND & RAYNER AVE.
(c) Hospital or institution:
WEST BALTIMORE GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. CAR. (b) County
(c) City or town SALISBURY
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MOSES B. NICHOLAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Dorothy Cauble
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1902

8. AGE: Years	Months	Days	If less than one day
43 44	11	25	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Grocery

FATHER
12. Name John R. Nichols
13. Birthplace Va.

MOTHER
14. Maiden Name Eva Richburne
15. Birthplace N. C.

16 (a) Informant Dan. Nicholas
(b) Address Salisbury N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Chestnut Hill Cem
Location Salisbury N. C.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1200 Eutaw Place

19 (a) (b)

NOV 22 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1946 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21/ 1946 to 11/21 1946 and that I last saw him alive on 11/21 1946

Immediate cause of death PULMONARY EDEMA — Duration

Due to MONOCYTIC LEUKEMIA

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy LEUKEMIC INFILTRATION OF LIVER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Lubinsky M.D.
Address 3704 Rondale Rd Date signed 11/22/46

correct age is especially important. If unknown, state approximate age.

G15770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 W. Ostend St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 W. Ostend St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bittner Butschky

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 217-14-1677

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Clara E. Butschky
6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) Nov 19. 1883

8. AGE: Years	Months	Days	If less than one day
63	0	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Bank Clerk
11. Industry or business Union Trust Co of Md

FATHER
12. Name Joseph N. Butschky
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Henrietta Burger
15. Birthplace Balto. Md.

16 (a) Informant: Clara E. Butschky
(b) Address 1301 W. Ostend St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23, 1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave
18 (a) Funeral director Mr. Mrs. John H. Deufel & Son
(b) Address 5311 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 22 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1946, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1946 to Nov 20 1946, and that I last saw him alive on Nov 20 1946.

Immediate cause of death: Coronary Occlusion — Duration: 24 hr.
Due to: Arteriosclerosis of coronary arteries — 6 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John A. Uhlrich Jr. M. D.
Address 1227 N Wash Blvd Date signed 11/20/46

Correct age is especially important. Physicians please write.

G15771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 E. Madison st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1315 E. Madison st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Cromwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	widowed

6 (b) Name of husband or wife Paul Cromwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-23-1893

8. AGE: Years	Months	Days	If less than one day
53	3	20	hr. min.

9. Birthplace Monkton, Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Samuel Dorsey
13. Birthplace St. Mary County. Md

MOTHER
14. Maiden Name Carrie Rainbow
15. Birthplace Reisterstown. Md.

16 (a) Informant Minnie Cromwell
(b) Address 1315 E. Madison st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Maryland.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson St

19 (a) (Date received by Local Registrar) NOV 2 1946 (b) Huntington Williams Mgr.

NOV 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1946, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1944, to Nov 20 1946, and that I last saw h alive on Nov 15 1946

Immediate cause of death

Cerebral Hemorrhage

Due to Essential Hypertension

Due to

Other Conditions Hypertensive Heart Disease Hypertrophic Arthritis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emerson R. Julian

Address 434 E 23rd St Date signed 11/21/46

X

BC#

G15772 G60382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

Registered No. G15772

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 N. Arlington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Dingle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-46

8. AGE: Years | Months | Days 3 | If less than one day: Fract hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Herbert Dingle
13. Birthplace Manning S.C.

MOTHER — 14. Maiden Name Rebecca Lemon
15. Birthplace Manning S.C.

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 332 N. Schroeder St.

19 (a) (Date rec'd by Reg.) (b) Washington Nov 22 1946 Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1946 at 10 a M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 28 1946 to Nov. 20 1946 and that I last saw h[illegible] alive on Nov. 20 19

Immediate cause of death	Duration
HEMORRHAGIC DISEASE OF THE NEW BORN	3 days
Due to PREMATURITY	LIFE
Due to CONGENITAL SYPHILIS (?)	LIFE
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H Harvey
Address Johns Hopkins Hosp. Date signed 11/20/46

NOV 22 1946

G15773 BC# BALTIMORE CITY HEALTH DEPARTMENT G15773

CERTIFICATE OF DEATH 13668 / 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Foster Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marlene Wehrman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1944

8. AGE: Years	Months	Days	If less than one day
1	11	36 2	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Wehrman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hoffman
15. Birthplace Baltimore

16 (a) Informant James Wehrman
(b) Address 3218 Foster Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-23-46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM
Location GERMAN HILL RD.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) (Date rec'd by registrar) NOV 22 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1946, at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1946 to Nov. 20 1946, and that I last saw her alive on Nov 20 1946.

Immediate cause of death	Duration
Cardio-resp failure	
Due to Congestive heart failure & severe	3 days
Due to Congenital heart disease	years
Other Conditions Lobar Pneumonia - Left Mongolism	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas K. Finnerman M.D.
Address Mary Hosp. Date signed 11/24/46

157E

please write the causes of death clearly and legibly. Physicians: please see that age is especially important.

G15771 G15774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3302 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET HOFFERBERT

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Hofferbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1875.

8. AGE: Years	Months	Days	If less than one day
71	9	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business At home.

FATHER
12. Name Michael Mehring
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Catherine Eisenhauer
15. Birthplace Balto., Md.

16 (a) Informant George Hofferbert (Son)
(b) Address 3302 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd., Balto. Co. Md.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) (Date received by local registrar) NOV 22 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1946 9:15 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13-1946 to 11-19-1946. and that I last saw h[illegible] alive on 11-19-1946.

Immediate cause of death: Carcinoma of Stomach — Duration 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 10-25-46
Major findings of operation: Carcinoma of Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature N. F. Davidson M. D.
Address 321 Fidelity Date signed 11-22-46

correct age is especially important. Physicians: please write clearly and legibly.

VS 180

X

G15775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G15775 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 S. Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Simmont

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Harry T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Alexander Bosman
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Barbara Hartline
15. Birthplace Baltimore

16 (a) Informant George Simmont
(b) Address 3506 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

NOV 22 1946 (Date Received) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1946, at 5A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1942 to Nov 20 1946, and that I last saw h[illegible] alive on 11-19 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 6 days
Due to Chr arterio-sclerosis & Hypertension — Duration 4 yrs ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern Date signed 11-22-46

VS 150

X

G15776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G15776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eduard & Greene Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3143 Cliftmont Ave (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME William Jensen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Carrie Janis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1891

8. AGE: Years	Months	Days	If less than one day
55	10	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Stillman
11. Industry or business Standard Oil Co.

FATHER
12. Name Frederick W.
13. Birthplace Baltimore

MOTHER
14. Maiden Name L.E. Humphreys
15. Birthplace England

16 (a) Informant Carrie Jensen
(b) Address 3143 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) NOV 22 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1946, at 2:26 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1946 to Nov 19 1946 and that I last saw him alive on Nov. 19 1946

	Duration
Immediate cause of death Pulmonary Embolism - Pneumonia	
Due to Phlebothrombosis of Leg Veins	7 days
Due to	
Other Conditions Carcinoma of Stomach - Inoperable (Include pregnancy within 3 months of death)	
Date of operation Nov 14 1946	
Major findings of operation: Carcinoma of Stomach - Inoperable	
autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard J. Crom M. D.
Address University Hosp Date signed

VS 150

Huntington Williams, MD

11/19/46

G15777 G15777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital V

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Brightson V

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mildred M. Sherbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1901

8. AGE: Years	Months	Days	If less than one day
45	9	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Police
11. Industry or business Western Md. R.R.

FATHER
12. Name Charles
13. Birthplace Penna.

MOTHER
14. Maiden Name Eva Butler
15. Birthplace Baltimore

16 (a) Informant Mildred M. Brightson
(b) Address 811 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 27 1946

vs 19

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1946, at 3 40 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Chronic Valvular Heart Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Hoffmann M.D.
Medical Examiner.
Date signed 11/20/46

X

G13778 BALTIMORE CITY HEALTH DEPARTMENT G13778

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4709 York Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giuseppe Panzarella

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband~~ or wife Vincenzina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21 1863

8. AGE: Years	Months	Days	If less than one day
63	8	29	hr. min.

9. Birthplace Vallelunga Italy (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name Rosario Panzarella
13. Birthplace Italy

MOTHER
14. Maiden Name Michela Costanza
15. Birthplace Italy

16 (a) Informant Vincenzina Panzarella
(b) Address 4709 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1946, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1946, to 11/19 1946 and that I last saw ~~him~~ her alive on 11/19/46

Immediate cause of death (Principle) Cerebral Hemorrhage — Duration

Due to Arterio & Nephro Sclerosis & Hypertension — yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Duncan Black M. D.
Address Medical Arts Bldg Date signed

G15779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G15779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 Baylis
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) 46 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Baylis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Liberato Cantalupo

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Maria Donata
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1872

8. AGE: Years	Months	Days	If less than one day
74	6	18	hr. min.

9. Birthplace Campagna Salerno Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Tommaso Cantalupo
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Onnella
15. Birthplace Italy

16 (a) Informant Maria Donata Cantalupo (Wife)
(b) Address 1203 Baylis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25/46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Lawn
Location 7725 Eastern Ave

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (b) Huntingdon Hills, Md.
NOV 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1946, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12- 1943 to 11-20 1946, and that I last saw h[illegible] alive on 11-20-1946.

Immediate cause of death: Chr. Lymphatic Leukemia — Duration 3 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town.) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. L. Davidow M. D.
Address 3218 Eastern Ave Date signed 11-22-46

X

B.L- D-62956

G15780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600a

(Registered No. G15780)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Forbes St.
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) born there
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4907 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Slade James Allen Slade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-46

8. AGE: Years	Months	Days	If less than one day
0	0	0	7 hr. 56 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Alden Slade
13. Birthplace Mt. Savage, Md.

MOTHER
14. Maiden Name Jacqueline Louise Chase
15. Birthplace Winslow, Augusta

16 (a) Informant Jacqueline Slade
(b) Address 4907 York Road, Balto 12

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 22-1946 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Baltimore

18 (a) Funeral director A. Reiley Slade
(b) Address 4907 York Road

19 NOV 22 1946 (Date rec'd by registrar) (b) Huntington Willis, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-46 (day) at 4 1/2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1946 to Nov 22 1946, and that I last saw him alive on Nov 22 1946.

Immediate cause of death: Intracranial hemorrhage — Duration: 2 hours

Due to: Cerebral anoxia — Duration: 2 hours

Due to: Maternal shock — Duration: 2 hrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Dykema M. D.
Address Woman's Hospital Date signed 11-22-46

X

G15731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G15731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Georgia Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel A Bleakley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W. divorced

6 (b) Name of husband or wife Mary I. Bleakley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12 1876

8. AGE: Years	Months	Days	If less than one day
70	11	9	hr. min.

9. Birthplace Balto Co. Md (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Self

FATHER
12. Name William H. Bleakley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Laura Gravenstein
15. Birthplace Baltimore

16 (a) Informant Mr. William G. Bleakley
(b) Address 2903 W. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received NOV 28 1946 Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1946, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1946 to Nov 21 1946, and that I last saw h[illegible] alive on Nov 21 1946.

Immediate cause of death: Cardiac Failure — Duration

Due to

Due to

Other Conditions Carcinoma of Urinary Bladder

(Include pregnancy within 3 months of death)

Date of operation Nov 17 1946

Major findings of operation: Intestinal Obstructions

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Phillips M. D.
Address Md. Gen. Hosp Date signed Nov 24 1946

JL 196190 G15782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G15782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris James Moore or Morris Ames Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1871

8. AGE: Years	Months	Days	If less than one day
75	2	69 53	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

FATHER
12. Name Glecrie Moore
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Final disposition (Burial, cremation, removal) (b) Date thereof 11/22/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Fellows & Lane
(b) Address 1214 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) Huntington Phillips M.D.

NOV 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1946, 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1946, to Nov. 21 1946, and that I last saw him alive on Nov. 21 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardiovascular disease.	
Due to	
Other Conditions Pulmonary edema. Bronchopneumonia. Hernia. Ulcer of mouth (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Gibbs M. D.
Address Balti. City Hospitals Date signed 11/22/46

G15783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G15783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 7/10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 E. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Patrick O'Laughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Febry 1874

8. AGE: Years	Months	Days	If less than one day
72	9		hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Pennsylvania R.R

FATHER
12. Name unknown
13. Birthplace Ireland

MOTHER
14. Maiden Name unknown
15. Birthplace Ireland

16 (a) Informant Mrs William T. Harrington
(b) Address 3131 Belmont Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John J Gowan & Son
(b) Address 901-03 Hollins St

19 (a) (b) Huntington Williams, M.D.

NOV 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-46 19 at 12. M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-17- 1946 to 11-21 1946 and that I last saw h[illegible] alive on 11/21 1946

Immediate cause of death
Cardiorespiratory failure
Due to Bronchopneumonia
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hampton W Low Jr M. D.
Address St. Joseph's Hosp Date signed 11 Nov 46

VS 150

X

G15781 G15781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 S.East Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S.east Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A?Worrell

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James Worrell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.8,1878

8. AGE: Years	Months	Days	If less than one day
68	0 1	24 13	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Lomax Bowler
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Jane --
15. Birthplace Va.

16 (a) Informant Mrs.Frank Lutz
(b) Address 33 S.East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov.23/46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by Registrar) (b)

NOV 22 1946

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov.21.1946 19 at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1940 to Nov. 21 1946 and that I last saw her alive on Nov. 20 1946

Immediate cause of death	Duration
Myocarditis (Chronic)	6 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cassagne M. D.
Address 5-14 Druid Lane Date signed 11/22/46

G15785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G15785 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Boarman Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Boarman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wilson Davis,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife Catherine Davis,
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 24, 1875

8. AGE: Years	Months	Days	If less than one day
70	10	26	hr. min.

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation Retired Lieut. Detective
11. Industry or business Balto. Police Dept.

FATHER
12. Name George W. Davis,
13. Birthplace Baltimore City,

MOTHER
14. Maiden Name Ellen Corcoran,
15. Birthplace Maryland.

16 (a) Informant Miss Eleanor Davis,
(b) Address 2811 Boarman Ave.

17 (a) Burial (b) Date thereof 11/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (b) Registrar
(Date rec'd by registrar)

NOV 22 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Nov. 20, 1946 19 , at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1946 to 11/20 1946, and that I last saw h im alive on 11/20, 1946

Immediate cause of death	Duration
Acute dilatation of heart	1 day.
Due to Myocarditis	2 yrs.
Due to Asthma	3 yrs.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Sigmar Pirosh M. D.
Address 2202 W. North Ave. Date signed

Sigmar Pirosh X

C15786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. C15786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3623 Manchester Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 Manchester Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Rogers,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife John T. Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1866

8. AGE: Years	Months	Days	If less than one day
80	6	3	hr. min.

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at home

FATHER
12. Name Thomas Lynch,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Montague,
15. Birthplace Ireland,

16 (a) Informant Mrs. Carl W. Scarborough,
(b) Address 3623 Manchester Ave.

17 (a) burial (b) Date thereof 11/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore City,

18 (a) Funeral director C. Vernon Timmons.
(b) Address 4611 Park Heights Ave.

19 (a) NOV 22 1946 (b) Registrar
(Date received by registrar)

Huntington Williams, M.D.

Correct Age is especially important. Physicians, please write plainly.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1946 at 1045 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1946 to 11/20 1946, and that I last saw h BF alive on 11/20 1946

Immediate cause of death

Mitral Insufficiency

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos A Burbert M. D.
Address 4803 Park Heights Date signed 11/24/46

X

G15787 G15787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 470

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Harsey, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Zuccarini

3 (b) If veteran, name war 1 | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1885

8. AGE: Years	Months	Days	If less than one day
61	8	12	hr. min.

9. Birthplace State (Town, county, and state)
10. Usual Occupation Car Repairman
11. Industry or business B & O R.R.

FATHER
12. Name Anthony Zuccarini
13. Birthplace Italy

MOTHER
14. Maiden Name Maria —
15. Birthplace Italy

16 (a) Informant Mary J Zuccarini
(b) Address Dorsey Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24/46 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Harsey, Md.

18 (a) Funeral director Harry W Wight
(b) Address 4101 Edmondson ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 22 1946 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1946 at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1946 to 11/21 1946 and that I last saw h alive on 11/21 1946

Immediate cause of death	Duration
Pneumothorax Heart probable	
Due to Cardio-resp. failure	
Due to	
Other Conditions Ca left lung.	

(Include pregnancy within 3 months of death)
Date of operation 11/21/1946
Major findings of operation: Ca left lung;
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F Tricker
Address Univ Hosp. Date signed 11/21/46 M. D.

correct age if obviously impossible. If uncertain, say about.

G15788 G15788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1458

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 Lyndhurst St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel W. Curville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Frances H. Linck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22 1873

8. AGE: Years	Months	Days	If less than one day
72 74	11	29	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business First Nat. Bk.

FATHER
12. Name Curville
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace Va.

16 (a) Informant Mrs. Frances Curville
(b) Address 318 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.

18 (a) Funeral director Harry A. Little
(b) Address 4101 E Edmondson ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Nov 21 1946 and that I last saw him alive on Nov. 21 1946.

Immediate cause of death	Duration
generalized carcinomatosis	2 week
Due to primary carcinoma of tongue	8 month
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation August 46
Major findings of operation: Ca - tongue
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H W Scheye

Address H. W. SCHEYE. M. D. 3921 EDMONDSON AVE. BALTIMORE-29. MD. Date signed 11-22 M. D. 1946

VS 150 NOV 22 1946 Huntington Williams, M.D.

G15789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G15789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2545 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2545 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank C. Rifkie

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife late Nellie (Dalcke)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1886

8. AGE: Years	Months	Days	If less than one day
60	7	3	hr. min.

9. Birthplace (Germany) Balto Md
(Town, county and state)
10. Usual Occupation Dough mixer
11. Industry or business Koester Bakery

FATHER
12. Name Henry Rifkie
13. Birthplace Germany

MOTHER
14. Maiden Name (Unknown) Aethe
15. Birthplace Unknown

16 (a) Informant Mrs Dalcke Rifkie
(b) Address 2545 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A Wolfe
(b) Address 4101 Edmondson Ave

19 (a) Nov 22 1946 (Date rec'd by registrar) (b) Huntington Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1946 to 11/20 1946 and that I last saw him alive on 11/19 1946.

Immediate cause of death	Duration
Carcinoma of Oesophagus	3 mos
Due to	
Due to	
Other Conditions Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Cahn M. D.
Address 2145 W Balto St Date signed 11/21/46

VS 180

Dr. Groosfeld
G15730

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G15730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5410 Knell Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5410 Knell Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sigmund Michaelski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Leopoldine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1870

8. AGE: Years	Months	Days	If less than one day
76	1	11	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Leopoldine Michaelski
(b) Address 5410 Knell Avenue, -6-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by Registrar) (b) Registrar

NOV 22 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 18 19 46 to Nov 21, 19 46 and that I last saw him alive on 11-21 19 46.

Immediate cause of death: (a) Coronary Thrombosis — Duration

Due to

Due to Senile Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael Groosfeld M. D.
Address 5402 Belvedere Date signed 11-22-46

X

G15791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G15791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 W Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V°
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs R

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 W Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton B. Elmore, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Estelle Elmore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1864

8. AGE: Years	Months	Days	If less than one day
82	0	26	hr. min.

9. Birthplace Brooklyn, N. Y. (City, county, and state)

10. Usual Occupation Boot Maker

11. Industry or business Jos. E. Lewis

FATHER
12. Name Richard Elmore
13. Birthplace Brooklyn N.Y.

MOTHER
14. Maiden Name Catherine Bannon
15. Birthplace Brooklyn N.Y.

16 (a) Informant Mrs. Catherine Light
(b) Address 2207 W Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory St Augustines Cem.
Location Elkridge, Md.

18 (a) Funeral director Jos. E. Lewis & Son
(b) Address 901-03 Hollins St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11, 21, 1946 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1946. to Nov. 21 1946. and that I last saw him alive on Nov. 20 46.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 1/2 min.
Due to Hypertension Cardio-Vascular Disease	10-15 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton B. Gallagher M. D.
Address Catonsville 28, Md. Date signed Nov. 22-46

Huntington Williams, M.D.

C15793

CWK-104968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

C15793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 Days
58- 8- 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3540 Clipper Road-Druid Park Dr.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Lomuel Taylor

3 (b) If veteran, name war: Navy

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Elizabeth Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 - 1888

8. AGE: Years	Months	Days	If less than one day
58	8	16	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business B. Md. R.R.

FATHER
12. Name George Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Moore
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23-1946 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3231 Fallstown Road

19 (a) (Signature of local registrar) (b) Filed Nov 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21- 19 46 at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 19 46 to Nov. 21 19 46, and that I last saw h im alive on Nov. 21 19 46

Immediate cause of death: Hypertension C.V. Disease — Duration: 3 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Baltimore City Hospitals Date signed 21 Nov 46

VS 150

X

G15793 BALTIMORE CITY HEALTH DEPARTMENT ✓ G15793
CERTIFICATE OF DEATH 57E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 10 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3634 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Moses Albert Parish

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mrs Moses Parish
6 (c) If alive, give age ! years
7. Birth date of deceased (mo., day, yr.) July 26, 1869
8. AGE: Years 77 Months 3 Days 26 If less than one day ____ hr. ____ min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business Housekeeper

FATHER
12. Name Moses Parish
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ruth Poole.
15. Birthplace Maryland.

16 (a) Informant Edna Talbot Parish
(b) Address 4607 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25-1946 (month) (day) (year)
(c) Cemetery or crematory Liquid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Durak Funeral Home
(b) Address 3631 Falls Road

19 (a) ____ (Date rec'd by registrar) (b) Lexington 7-8888, M

VS 150 NOV 29

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1946 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1946, to Nov 22 1946, and that I last saw h him alive on Nov 21 1946.

Immediate cause of death Neoplasm of st. lung. (Type unknown)

Duration 6 mos.

Burns Atelectasis due to Compression (st. lung)

3 days 30 days.

Due to

Other Conditions Arteriosclerosis general. Arteriosclerotic heart disease.
(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Rachmuth M. D.
Address Church Home & Hosp Date signed Nov 24, 46

X

G15794 ✓ G15794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2427 St. Paul Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Margaret Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John P. Lucas

(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Dec 7- 1900

8. AGE: Years 45 Months 11 Days 14 If less than one day hr. min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Joff

13. Birthplace Va

14. Maiden Name Garrett

15. Birthplace Balto. Md.

16 (a) Informant Santi Lucas

(b) Address 3500 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21-1946 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location Old Frederick Rd.

18 (a) Funeral director Joseph Sauer Inc

(b) Address 2013 Rhenmount Ave.

19 (a) Date received by registrar 11-25-1946 (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1946, at 5 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1943 to 11/9 1946 and that I last saw him alive on 11/9 1946.

Immediate cause of death: Pulm. embolism — Duration

Due to: Rheumatic Cardio-Uterus Disease Mitral Stenosis & insuff. — 2 yrs.

Due to: Thrombophlebitis (femoral)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Huntington Williams M.D.

Address 1211 Cathedral St. Date signed 11/25/46

X

3795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 186a

Registered No. C15795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Hammes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Stonewall Hammes
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 20-1862

8. AGE: Years	Months	Days	If less than one day
84	1	0	hr. min.

9. Birthplace Balto Md
(Town, county and state)
10. Usual Occupation a Housewife
11. Industry or business

FATHER
12. Name Samuel Longley
13. Birthplace Md

MOTHER
14. Maiden Name Sarah J Betts
15. Birthplace Md

16 (a) Informant Mrs Chas Nicholson
(b) Address 2002 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Londonderry
Location Balto Md

18 (a) Funeral director Geo L Boyer Jr
(b) Address 152 Hollins St

19 (a) Nov 22 1946 (Date filed by registrar) (b) Registrar Williams MR

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1946, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1946, to 11/20 1946 and that I last saw him alive on 11/20 1946.

Immediate cause of death Debilitation — Duration

Due to Decubitus Ulcers

Due to Fracture of Hip

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 15 1946 at 10 A M
(c) Where did injury occur? Balto Md 2002 Hollins St
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury: Fall down stairs

23. Signature William E. McCook M.D.
Address St Agnes Hosp Date signed 11 Nov 46
For Dr. Davis Hammes & Simmons

VS 150

796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

Registered No. G15796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 11 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Huntingdon Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PETER ALTHOFF

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. NONE

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife MARIE S. ALTHOFF

6 (c) If alive, give age # years

7. Birth data of deceased (mo., day, yr.) Feb. 1, 1878

8. AGE: Years 68 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Emmitsburg, Maryland (Town, county and state)

10. Usual Occupation RETIRED

11. Industry or business School Janitor

FATHER
12. Name William Althoff
13. Birthplace Emmitsburg, Maryland

MOTHER
14. Maiden Name Mary Warthen
15. Birthplace Emmitsburg, Maryland

16 (a) Informant Miss Helen Althoff
(b) Address 2817 Huntingdon avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)
(c) Cemetery or crematory Mt. St. Mary's
Location Emmitsburg, Maryland

18 (a) Funeral director Chas. J. Eyring & Sons
(b) Address 118 N. Mt. Royal Ave
Huntingdon Williams Mgr

NOV 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1946 at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1946 to 11-24 1946 and that I last saw h/her alive on 11-21 1946.

Immediate cause of death Congestive heart failure — Duration

Due to arteriosclerotic CV disease

Due to

Other Conditions Pneumonia, Colon

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. L. Franklin M. D.
Address Bon Secours Hosp Date signed N. 24 46

VS 190

G15737 — BALTIMORE CITY HEALTH DEPARTMENT — G15737 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 E Federal St
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 E Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella May Hays

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 5 1872

8. AGE: Years	Months	Days	If less than one day
74 72	6	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Joseph M. Batty
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ann Cecelia Lynch
15. Birthplace Baltimore

16 (a) Informant Walter L. Batty
(b) Address 2122 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Orleans St

19 (a) NOV 23 1946 (Date rec'd by registrar) (b) Registrar

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20th 1946 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 20 1946, and that I last saw h alive on Nov 17, 1946.

Immediate cause of death	Duration
Myocardial Insufficiency	7 days
Due to Arteriosclerosis	
Due to	
Other Conditions Hypertension Infection of face & head	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 1122 Eastern Ave Date signed 11/21/46 M. D.

G15798 BALTIMORE CITY HEALTH DEPARTMENT ✓ G15798
CERTIFICATE OF DEATH 186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Joseph's Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Wilcox Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Van Horn

3 (b) If veteran, name war N

3 (c) Social Security Account No. NONE

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George T. Van Horn
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lenora Grimes
15. Birthplace

16 (a) Informant Lenora Barr
(b) Address 4604 Asbury Ave

17 (a) Burial (b) Date thereof 11/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

Nov 23 1946 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1946, at 9 05 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-20-46 8 P. 10/1 M.
(b) Where did injury occur? 1114 Harford Ave (Street)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell striking head on floor

23. Signature Homer J. Wheeler M.D.
Medical Examiner.
Date signed 11-21-46

VS 191

G15799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939

G15799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5704 Merville Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5704 Merville Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARETTA BIDDLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Troy F. Biddle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1884

8. AGE: Years	Months	Days	If less than one day
62	4	18	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Connor
13. Birthplace England

MOTHER
14. Maiden Name Mary Shroh
15. Birthplace New York

16 (a) Informant Mrs. Kathryn Koelln
(b) Address 187 S. Oxford St. Brooklyn, N.Y.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 23 1946 (Date rec'd by local registrar) (b) Tom Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 22 1946, at 5.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 2 1946, to Nov. 22 1946, and that I last saw h-r alive on NOV 22 1946.

Immediate cause of death: ACUTE MESENTERIC THROMBOSIS — Duration: 2 DAYS

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE — ?

Due to

Other Conditions CEREBRAL HEMORRHAGE — JUN 2, 46

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Acton M.D.
Address 8 Longwood Road Baltimore 10, Md. Date signed 22 NOV 46

VS 150

G15800 | BALTIMORE CITY HEALTH DEPARTMENT | G15800 Registered No.

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3925 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3925 Park Heights Ave, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francesco (Frank) Paul Santilli

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Almerinda L. Santilli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1876

8. AGE: Years	Months	Days	If less than one day
70	9	0	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Self

FATHER
12. Name Joseph Santilli
13. Birthplace Italy

MOTHER
14. Maiden Name Giancinta Lebri
15 Birthplace Italy

16 (a) Informant Mrs. Almerinda L. Santilli
(b) Address 3925 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 23 1946 (b) (Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1946, at 4:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 to 11/21 1946 and that I last saw h[illegible] alive on 11/20/1946.

Immediate cause of death	Duration
(a) Uremia - Valvular heart disease	5 yrs
Due to (b) Uremia Nephritis	7
Due to (c)	
Other Conditions Chronic Nephritis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1901 Eutaw Pl Date signed 11/22/46

G15801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G15801 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th ST
(c) Hospital or institution:
The Home for Incurables - 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs 2
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Balto -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Clifton Ave. -
(If rural give location)
(e) Citizen of foreign country? U.S. - (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Ellsworth Nash -

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 - 1884

8. AGE: Years 62 | Months 2 | Days 29. | If less than one day hr. min.

9. Birthplace Balto. Maryland
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Harry Abbott

FATHER
12. Name John P. Nash -
13. Birthplace Balto. Md -

MOTHER
14. Maiden Name Catherine King
15. Birthplace Baltimore, Md -

16 (a) Informant The Home for Incurables
(b) Address Record - 700 W 40th ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Washington Nationals, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 at 7:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/23 1932 to 11/22 1946, and that I last saw h[illegible] alive on 11/24 1946

	Duration
Immediate cause of death: Cerebral Cardiac Dilatation	14 Hours
Due to: Coronary Sclerosis	6 months
Due to:	
Other Conditions: Arteriosclerosis	13 Years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hershberger M. D.
Address 214 Medical Cot Bldg Date signed 11/27/46

VS 8

G15803 — BALTIMORE CITY HEALTH DEPARTMENT — G15803 Registered No.

CERTIFICATE OF DEATH 1176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2801 Fait Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 2801 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Pietrowiak

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Anna Pietrowiak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1885

8. AGE: Years	Months	Days	If less than one day
61	9	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Hardware business
11. Industry or business Business

FATHER
12. Name John Pietrowiak
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Anna Pietrowiak
(b) Address 2801 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem.
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2029 Hudson St.

19 (a) 10th (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1946 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1946 to Nov 21 1946, and that I last saw h[illegible] alive on Nov 21 1946.

Immediate cause of death	Duration
Coronary Thrombosis 11/21	-
Myocarditis	1941
Due to Duodenal ulcer	1937
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A J Kaufman
Address 3426 Bank Date signed 11/25/46 M. D.

VS 186

X

G15803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15803 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 738 W Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Earl Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ? 1864

8. AGE	Years	Months	Days	If less than one day
	82			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adam Kraft
13. Birthplace Germany

MOTHER
14. Maiden Name Anastatia ?
15. Birthplace Germany

16 (a) Informant Mrs Andrew Reff
(b) Address 3032 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Edgar Hoffman
(b) Address 1115 E. Westfall

19 (a) NOV 23 1946 (Date rec'd by registrar) (b)

Furniture for Williamsport Md

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18/46 19 . at 6:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 11/19/46

G15801 — BALTIMORE CITY HEALTH DEPARTMENT — G15801

CERTIFICATE OF DEATH

504795 / 108 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 / 15
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4127 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Agarinah Jones (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 9-29-69

8. AGE: Years	Months	Days	If less than one day
77	1	20	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired Salesman

FATHER
12. Name Agarinah Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Price
15. Birthplace Md.

16 (a) Informant Reconda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 22 / 4 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.
18 (a) Funeral director Chas E Cross
(b) Address Benson, Md.
19 (a) 1946 (b) Dayton Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1946, at 7.37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17. 1946. to Nov 19 1946. and that I last saw him alive on Nov. 19 1946.

Immediate cause of death: Arteriosclerotic heart disease with cardiac enlargement & failure — Duration
Due to: Pneumonia, lobar due to Pneumococcus, type 3
Due to: Urinary obstruction due to benign prostatic hypertrophy
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Anstham, M.D.
Address Johns Hopkins Hosp Date signed Nov 22 1946

Correct age is especially important. Physician: please write plainly.

VS 150

G15805 G04371 DCH

Medical Exam case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 B

G15805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Millman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred M^c Glotten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1944

8. AGE: Years	Months	Days	If less than one day
2	6		hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas

13. Birthplace

MOTHER 14. Maiden Name Bertina

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1001 Bloomsbury Ave

19 (a) 1946 (Date rec'd by registrar) (b) Wilmington Williams M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Nov. 21 1946 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1946 to Nov. 21 1946 and that I last saw him alive on Nov. 21 1946.

Immediate cause of death: Pulmonary respiratory failure — Duration 1 hr.

Due to Heart failure — 1 hr.

Due to Hemophilus influenza

Other Conditions Meningitis type c, present at autopsy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hugh H. Bowers Jr M. D.

Address Harriet Lane J. H. H. Date signed 11/21/46

Howard J. Curtis, M.D.

VS 150

support age is especially important. Physicians: please write out all words.

G15806
504904

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH / 83B

G15806
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Maple Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harrison A. Armour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Stella M
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 9-26-74

8. AGE: Years	Months	Days	If less than one day
72	1	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Charles Armour
13. Birthplace Md.

MOTHER
14. Maiden Name Susan M. Cubb.
15. Birthplace Md

16 (a) Informant Regnda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry F. Mentzel
(b) Address 4101 Edmondson Ave

19 (a) NOV 23 1946 (b) (Date rec'd by registrar) Registrar
Huntington Williams, MD

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 22 1946 at 5.09 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946 to Nov. 22 1946, and that I last saw h[illegible] alive on Nov 22 1946.

Immediate cause of death
a Coma
Cerebral hemorrhage
Due to: b Renal insufficiency
c Chronic nephritis
Due to: d Arteriosclerosis Benign prostatic hypertrophy
Other Conditions

Duration
3 days
1 yr

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Armour
Address 1 HH Date signed 11-23-46 M. D.

VS 150

X

G15807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

To [illegible] Chief [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Paca St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio Portera (Tony Portera) (Portiera) Sr.
3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Sarah Portera
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1877
8. AGE: Years 69 | Months — | Days — | If less than one day hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER / PARENTS
12. Name Salvatore Portera
13. Birthplace Italy
MOTHER / PARENTS
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Tony Portera Jr
(b) Address 27 S. Potomac Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Fehrer
(b) Address 2101 Frederick Ave.

19 (a) NOV 29 1946 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1946, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1946 to Nov 22 1946, and that I last saw him alive on Nov 22 1946.

Immediate cause of death: Terminal Bronchial Pneumonia — Duration
Due to: Inactivity
Due to: Fractured femur (right) Bladder tumors
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 17/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct 26, 1946 about 6 A.M.
(c) Where did injury occur? Baltimore, Md. Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Fall in the room
23. Signature Wm. F. Crouch M. D.
Address University Hosp. Date signed 11-28-46

Huntington Williams, M.D.

Approved Wm. F. Helfrich, M.D.

correct age is especially important. Physicians: please write out answers to all questions.

G15808 BALTIMORE CITY HEALTH DEPARTMENT G15808
Registered No.

CERTIFICATE OF DEATH 1170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 N. Caroline Street
(c) Hospital or institution: St. Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto.
(c) City or town 428 Fort Ave. Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Conrad Pong - Long

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married.

6 (b) Name of husband or wife Annie E Long (Mabel)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1865

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	5	16		25

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frank Long.
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Winkler
15. Birthplace England.

16 (a) Informant Mrs. Irene E Dorn.
(b) Address 408 Oakdale.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 23 46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Essex
18 (a) Funeral director John F Connelly.
(b) Address 418 Eastern Ave. Catonsville.
19 (c) 23 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1946 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1946 to 11/20 1946, and that I last saw h[illegible] alive on 11/20 1946.

Immediate cause of death: (Duration)
Pneumonia - Cardiac failure
Due to generalized peritonitis
Intestinal obstruction
Due to perforated gastric ulcer & Dermoid cyst
Other Conditions Left testicle
(Include pregnancy within 3 months of death)

Date of operation 11/19/46
Major findings of operations Peritonitis Dermoid cyst - Left testicle
of autopsy Also perforated gastric ulcer

PHYSICIAN: (Underline the cause to which death should be referred statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Stokes M. D.
Address St. Joseph's Hosp. Date signed 11/20/46

VS 150

G15809 — BALTIMORE CITY HEALTH DEPARTMENT — G15809

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 N. Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 N. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JOSEPH DRNEC

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mary J. (nee Supik)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1886

8. AGE: Years	Months	Days	If less than one day
60 yrs.	9	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Vincent Drnec
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace Czechoslovakia

16 (a) Informant Wife
(b) Address 1026 N. Castle St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) 23 1946 (b) Walter Williams, M.D. Registrar
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1946, at 11 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Nov 20 1946, and that I last saw [illegible] alive on Nov 20 1946.

Immediate cause of death	Duration
Acute Dilatation Heart	1 day
Due to Coronary Thrombosis	3 days
Due to	
Other Conditions Chronic Myocarditis	2 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E Gill Hall
Address 1631 E. North Av Date signed 4/22/46 M. D.

correct age is especially important. Physicians please write plainly.

VS 150

X

G15810 G15810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4610 Springdale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur B. MacGreal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jane MacGreal
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 27, ~~1884~~ 1883

8. AGE: Years	Months	Days	If less than one day
61 (62)	5	25	hr. min.

9. Birthplace St. John, Quebec (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business

FATHER
12. Name Lawrence MacGreal
13. Birthplace England

MOTHER
14. Maiden Name Mary Leicester
15. Birthplace England

16 (a) Informant Mrs. Jane MacGreal
(b) Address 4610 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Methodist Cem
Location Hillsdale, Pa.

18 (a) Funeral director Miller Lawrence
(b) Address 4610 Liberty Heights Ave.

19 (a) 1946 (b) Received by registrar Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946 at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 22 1946 and that I last saw him alive on Nov 20 1946

Immediate cause of death Coronary Thrombosis

	Duration
Due to Ruptured Aneurysm ?	
Due to	
Other Conditions Coronary Thrombosis Hypertension Cardiovascular Renal (Include pregnancy within 3 months of death) ?	Years

Date of operation
Major findings of operation:
of autopsy Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Rosenthal M. D.
Address [illegible] Date signed 11/25/46

VS 150

G15811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √13B

G15811 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Monroe Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Brunt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith Turner Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Zack Moore
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Jerry Robinson
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Robinson
15. Birthplace Maryland

16 (a) Informant Clara Turner
(b) Address 2133 Pennsylvania Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 24 46 (month) (day) (year)
(c) Cemetery or crematory
Location Stevensville Md

18 (a) Funeral director Isaiah L Brown Son
Address 1080 W Montgomery St

19 (a) NOV 23 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1946, at 9 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1946 to Nov. 19, 1946, and that I last saw h[illegible] alive on Nov. 19, 1946

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Disseminated Tuberculosis of brain, meninges, lungs, larynx, intestines, spleen, & mesenteric glands	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: See Above
of autopsy: See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Stacy E. Hill, M.D.
Address Home - Hospital Date signed 11/19/46

correct age is especially important. Physicians, please [illegible]

VS 150 Huntington Williams, M.D.

G15813 — BALTIMORE CITY HEALTH DEPARTMENT — G15813 Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 Richardson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 Richardson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Sophia Brokos

3 (b) If veteran, name war | 3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Joseph Brokos
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 10/ /1880

8. AGE: Years	Months	Days	If less than one day
66	1	15	12 hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Leonard Brokos
(b) Address 1335 Richardson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Chas F Dull
(b) Address 1511 E. Fort Ave.

19 (a) Washington Williams, M.D. (b) Registrar
(Signature of registrar)

23 1946
VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21/1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1946 to 11/20 1946, and that I last saw h[illegible] alive on 11/20 1946.

Immediate cause of death
Chronic nephritis
Hypertensive C.V.D.
Due to Terminal uremia
Terminal Bronchi-
Due to Pneumonia

Duration
one Life

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 107 E. West St Date signed 11/23/46

X

G15813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15813 Registered No. 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 N Brice St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 N Brice St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara E. Reier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Paul A. Reier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1874

8. AGE: Years 82 | Months 5 | Days 5 | If less than one day: hr. 18 min. 64

9. Birthplace Germany (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name G. C. Kerst
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Emma Reier
(b) Address 537 N Brice St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location

18 (a) Funeral director Chas E Powell
(b) Address 2427 Edmondson Ave

(a) Date received NOV 23 1946 (b) Registrar

VS 180

correct age is especially important. Physicians, please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1946, at 4:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1946 to Nov 23 1946, and that I last saw alive on Nov 23 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: Days
Due to: Arterio-Sclerosis — 15 yrs
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos L Zierler M. D.
Address 2318 Eutaw Place Date signed Nov 25 1946

Registrar Huntington Williams, M.D.

G15814 G15814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Johnson St. #30 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. DOROTHY T. O'DONNELL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Hugh V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1892

8. AGE: Years 54 | Months 1 2 | Days 2 2 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name PETER Gottlieb
13. Birthplace Md.

MOTHER 14. Maiden Name MARGARET Kirby
15. Birthplace Md.

16 (a) Informant Mrs. Hugh V. O'Donnell
(b) Address 1732 Johnson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope
Location Baltimore Md

18 (a) Funeral director J. E. McCully
(b) Address 130 E. Fort Ave.

19 (a) (b) Date received by registrar Livingston Williams, M.D. NOV 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1946, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1946, to 11-21 1946, and that I last saw h[illegible] alive on 11-21 1946.

Immediate cause of death Massive pulmonary embolism

Due to Post-operative cholecystectomy

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 15 Nov 46

Major findings of operation: Cholecystitis with cholelithiasis

of autopsy —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Carlton Bromfield, M.D. M. D.
Address Maryland General Hosp. Date signed 11-22-46

Correct age is especially important. Physicians please write plainly.

G15815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G15815
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Aliciana
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Clyde

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-1932

8. AGE: Years	Months	Days	If less than one day
14	7	10	hr. min.

9. Birthplace Penn
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wayne J. Clyde
13. Birthplace Penn

MOTHER
14. Maiden Name Celia Kifer
15. Birthplace Penn

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemy.
Location Windsor Mill Rd. Balto, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) 23 1946 (b) Huntington Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1946 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946 to Nov 20 1946 and that I last saw her alive on Nov. 20 1946.

Immediate cause of death Resp. paralysis

Due to Polio encephalitis

Due to

Other Conditions Convulsions

(Include pregnancy within 3 months of death)

Date of operation 11-20-46

Major findings of operation: Autopsy

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Druss M. D.
Address J H H Date signed 11-20-46

Correct age is especially important. Physicians: please write plainly.

C15816 C15816

505046.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Dania (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 S.W. 12th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Lyna Ragatz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-44

8. AGE: Years	Months	Days	If less than one day
2	7	11	hr. min.

9. Birthplace Fla (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ree H. Ragatz
13. Birthplace Mich

MOTHER
14. Maiden Name Doris Mary Lepkin
15. Birthplace Mich

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 23-46 (month) (day) (year)
(c) Cemetery or crematory PERRY MOUNT PARK
Location PONTIAC MICH.

18 (a) Funeral director John D Mitchell Sons
(b) Address 1500 Eutaw Pl.

NOV 23 1946 (Date received by registrar) (b) Huntington Willis

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov-23 1946 at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-21 1946 to Nov-23 1946 and that I last saw him alive on Nov-23 1946.

Immediate cause of death Cerebral Anoxia — Duration 18 hrs

Due to Tetralogy of Fallot Hydrocephalus — Duration Life

Due to

Other Conditions Operation for pulmonic stenosis. (Include pregnancy within 3 months of death)

Date of operation 11/22/46

Major findings of operation: Tetralogy of Fallot

of autopsy Same. Hydrocephalus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry F. Bahmon M.D.
Address Johns Hopkins Hospital Date signed 4/27/47

correct age is especially important. Physicians: please write

VS 150

C15817 CWK-106153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

C15817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 15 b

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eve Bell Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15-1901

8. AGE: Years	Months	Days	If less than one day
45	7	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Nelson
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Coleman
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/46 (month) (day) (year)

(c) Cemetery or crematory Fellowship
Location Virginia

18 (a) Funeral director Leroy O. Wilson
(b) Address 1000 Bloomsbury Ave

19 (a) 1946 (Date rec'd by registrar) (b) Clayton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1946, at 3:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1946 to Nov. 20 1946, and that I last saw her alive on Nov. 20 1946.

Immediate cause of death Primary Pulmonary Tuberculosis 7 mos - 7 years?

Duration

Due to

Due to

Other Conditions Hypertension C-V Disease. Senile Cerebral Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Fowler, Jr. M. D.
Address Balto City Hospitals Date signed 11-25-46

VS 150

X

G15818 BC# F86587 — G15818 — 54 B

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd st.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Still Pond, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Camille Jennifer Van Winkle

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1943

8. AGE: Years	Months	Days	If less than one day
3	1	16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Not Employed
11. Industry or business

FATHER
12. Name John A. Van Winkle.
13. Birthplace New Jersey

MOTHER
14. Maiden Name Edith Reynolds
15. Birthplace New Jersey.

16 (a) Informant Parent. John A. Van Winkle
(b) Address Still Pond, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27/46 (month) (day) (year)
(c) Cemetery or crematory Still Pond
Location Still Pond Md

18 (a) Funeral director B R Fellows
(b) Address Still Pond Md

19 (a) NOV 27 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1946, at 9:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1946, to Nov 23 1946, and that I last saw h.e alive on Nov 23 19 46.

Immediate cause of death: Respiratory failure — Duration: 4 mos
Due to: Tumor of pons (intracranial tumor)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Pontine tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold N. Cooper M. D.
Address Union Memorial Hospital Date signed 27 Nov 1946

VS 150

G15819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 477

G15819
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.,
(c) Hospital or institution: US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 Graydon Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BASS, Charles Frederick

3 (b) If veteran, name war World War I

3 (c) Social Security Account No. 225-22-6480

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Fletcher Bass

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) April 8, 1888

8. AGE: Years 58 | Months 6 | Days 13 | If less than one day 15 hr. min.

9. Birthplace Pensacola, Florida (Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business Seafaring

FATHER
12. Name Andrew Bass,
13. Birthplace Denmark

MOTHER
14. Maiden Name Ellen Brennan
15. Birthplace New York

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26-46 (month) (day) (year)
(c) Cemetery or crematory Forrest Lawn
Location Norfolk Virginia

18 (a) Funeral director E. Unsworth & Associates
(b) Address 3911 Liberty Heights Ave

19 (a) 1946 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1946 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1946, to Nov. 23, 1946, and that I last saw him alive on Nov. 23, 1946.

Immediate cause of death Carcinoma, Rt. Lung — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Walker M. D.
Address U. S. Marine Hospital Baltimore 11, Md. Date signed 11/28/46

Correct age is especially important. Physicians: please write clearly.

VS 190

G15820 — BALTIMORE CITY HEALTH DEPARTMENT — G15820 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4514 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4514 Arabia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Scherer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Veronica V. Scherer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21-1863

8. AGE: Years	Months	Days	If less than one day
83	2	1	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Tailor
11. Industry or business

FATHER
12. Name Scherer
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant John W. Scherer
(b) Address 4514 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25-46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave. & Gay St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 1946 Received by registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946, 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946, to Nov 22 1946, and that I last saw [illegible] alive on Nov 22 1946.

Immediate cause of death	Duration
Chronic myocarditis	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury None

23. Signature [illegible] M. D.
Address 5106 Roland Ave Date signed 11-22-46

Correct age is especially important. Typewrite, print or write with pen and ink.

VS 150

G15821 G15821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 137 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	(Single) Married

6 (b) Name of husband or wife Carrie H. Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1904 (Feb. 6, 1905)

8. AGE: Years	Months	Days	If less than one day
42 (41)	10 (9)	16	hr. min.

9. Birthplace Winston-Salem, N.C. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

BOTHER / FATHER

12. Name Robert Cooper
13. Birthplace N.C.
14. Maiden Name Maggie Sighford
15. Birthplace N.C.

16 (a) Informant Robert Cooper
(b) Address Winston Salem N.C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Family lot
Location Kiaota - Salem, N.C.

18 (a) Funeral director Jno. Carr & Sons, Baltimore, Md.
(b) Address 1601 Druid Hill Ave.

19 (a) Huntington Williams, M.D. Registrar
(Date filed by registrar) 24 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1946, at 6:7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1946, to Nov. 22, 1946, and that I last saw him alive on Nov. 22 1946.

Immediate cause of death: Pulmonary Congestion — Duration

Due to Congestive Heart Failure

Due to Aortic Aneurysm

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald M. D.
Address 844 N Carey Date signed 11/25/46

Correct Age is especially important. Physicians, please write out.

X

G15823 BALTIMORE CITY HEALTH DEPARTMENT G15823
CERTIFICATE OF DEATH 13 B
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 FLEET ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 FLEET ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME STANISLAW JAMES WRZOSEK (JASAC)

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. 215-09 6410

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife WLADYSLAWA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 / 1888

8. AGE: Years	Months	Days	If less than one day
58	7	17	hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name FELIX WRZOSEK
13. Birthplace POLAND

MOTHER
14. Maiden Name UNK.
15. Birthplace POLAND

16 (a) Informant WLADYSLAWA WRZOSEK
(b) Address 1603 FLEET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 25/46 (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location BALTIMORE

18 (a) Funeral director Brad W Ozarzewski
(b) Address 1930 Eastern Ave

19 (a) (b)
(Signature by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 21 1946 at 7.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1946 to Nov 21 1946 and that I last saw him alive on NOV 21 1946.

Immediate cause of death
(a) Uremia Cardiac Arrest 11/21/46
Due to Pulmonary T.B. 6-1-46
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Rybarczyk M.D.
Address 811 Reservoir Date signed

VS 150

G15823 BALTIMORE CITY HEALTH DEPARTMENT X G15823
CERTIFICATE OF DEATH ✓ 170 c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Pa[illegible]ley Quarters (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. O'Donnell

3 (b) If veteran, name war: World II

3 (c) Social Security Account No.: ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Patricia B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 20, 1922

8. AGE: Years: 24 Months: 8 Days: 7 If less than one day: hr. min.

9. Birthplace: Howard Co Md (Town, county, and state)

10. Usual Occupation: Glenn L Martin

11. Industry or business

FATHER
12. Name: Wm A O'Donnell
13. Birthplace: Md.

MOTHER
14. Maiden Name: Lillian E Broesme
15. Birthplace: Md

16 (a) Informant: Mrs. Wm C O'Donnell
(b) Address: Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-26-46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore Md

18 (a) Funeral director: J.C. Hyndshaw
(b) Address: Ellicott City Md

19 (a) 1946 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1946, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Ruptured Thoracic Aorta
Ruptured Spleen
Due to Hemothorax & Hemoperitoneum
Other Conditions Multiple bruises & lacerations.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-22-46 at 5:50 P.M. Howard Co.
(b) Where did injury occur? Route #40 ½ mile east of Rogers Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto & Auto Collision

23. Signature Howard J. Thaler M.D.
Medical Examiner.
Date signed 11-23-46

VS 181

X

G15831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/32a

G15831 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lindsew & Madison
(c) Hospital or institution Md. Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Battolaty
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W Mulberry (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME (CHIN PON) Lee Dai

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: Yellow
6 (a) Single, married, widowed, or divorced: — ? —
6 (b) Name of husband or wife: — ? —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About 1897

8. AGE: Years: About 48 | Months: - | Days: - | If less than one day: hr. min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Restaurant

FATHER
12. Name unknown
13. Birthplace China

MOTHER
14. Maiden Name unknown
15. Birthplace China

16 (a) Informant Jno. J. Molson (cousin)
(b) Address 217 W Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Sliwas Mazuta Co.
(b) Address 108 W Monk Ave.

11-24-1946 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1946, at 8 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1946 to 11/23 1946 and that I last saw h[illegible] alive on 11/23 1946.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 4 HRS.
Due to HYPERTENSIVE DISEASE
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Charles W. Stewart, Jr. M.D.
Address M Gen Hospital Date signed 11/24/46

VS 150

X

G15825 | BALTIMORE CITY HEALTH DEPARTMENT | G15825 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (~~Balto~~) Caton Av
(b) Street address
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md.~~ Ohio (b) County Cuyahoga
(c) City or town ~~Baltimore~~ Cleveland
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1415 Linden Ave.~~ 3221-Oak Rd-18
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH DUGAN JOSEPH HODGES DUGAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emily J. Dugan
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) DEC-24-1900

8. AGE: Years	Months	Days	If less than one day
45	10	29	hr. ___ min. ___

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Production Engineer
11. Industry or business Self-employed.

FATHER
12. Name Jos. M. Dugan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eleanor Hodges
15. Birthplace Elliott City Md.

16 (a) Informant Mr. Jos. Hodges (Uncle)
(b) Address 1415 Linden Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 25-46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Sturdivant Morris Co.
(b) Address 108 W Monk Ave.

19 (a) [illegible] (b) Date rec'd by registrar Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1946 at 7:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Ruptured Spleen
Hemorrhage of abdomen
Due to Subarachnoid Hemorrhage

Other Conditions Multiple fractures, lacerations, abrasions & contusions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-22-46 at 5:50 P.M. Howard Co.
(b) Where did injury occur? 1/2 mile east of Rogers Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury auto & auto collision

23. Signature Howard J. Madison M.D. (Medical Examiner)
Date signed 11-23-46

G15826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15826 Registered No. 1246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3439 Barclay St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Clemens.

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Anna R. Brewer
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 6-27-1890

8. AGE: Years 56 | Months 4 | Days 25 | If less than one day ########## min.

9. Birthplace Baltimore (City, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Unemployed

FATHER
12. Name Eugene Clemens
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary?
15. Birthplace ?

16 (a) Informant Mrs. Hilda L. Straub (Daughter)
(b) Address 2439 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory Morelands Park
Location Taylor Avenue, Balto: Co.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 24 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 22 1946 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1946 to 11-22 1946, and that I last saw him alive on 11-22 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Hematemesis	
Due to Ruptured esophageal varices	
Other Conditions Portal cirrhosis Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address Calvert + Saratoga Sts Signed 11-22-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

X

copy age is especially important. Physician: please

G15837 BALTIMORE CITY HEALTH DEPARTMENT G15824
CERTIFICATE OF DEATH 836
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves.
(c) Hospital or institution: Levindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 N. Patt. Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME BENJAMIN POMERANTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Ida Pomerantz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER
12. Name William —
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Ralph Pomerantz
(b) Address 1424 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rodeph Shalom
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1739 E. Balto. St

19 (a) 1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1946, at 10 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1944 to 11-22 1946, and that I last saw h i m alive on 11-22 1946

Immediate cause of death Bilateral bronchopneumonia — Duration

Due to

Due to

Other Conditions Cerebral thrombosis hemiplegia dextra
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry W Boyd M. D.
Address Levindale Home Date signed 11-22-46

Correct age is especially important. Physicians: please write clearly and legibly.

VS 180

107

G15828 BALTIMORE CITY HEALTH DEPARTMENT G15828
CERTIFICATE OF DEATH 95c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 Warwick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Warwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aaron L. Friedman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1874
8. AGE: Years 72 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Sol
13. Birthplace Russia

MOTHER
14. Maiden Name Doris
15. Birthplace Russia

16 (a) Informant Ben Friedman
(b) Address 1736 Warwick Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-46 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Phila Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St
19 (a) (Date rec'd by registrar) (b) Livingston Williams, Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 11-23- 1946 10A 45 M
21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Nov 23 1946 and that I last saw h[illegible] alive on 11/23 1946.
Immediate cause of death Pulmonary Emphysema - Senile type
Due to Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
4-5 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George Shlossman M.D.
Address 5166 Park Heights Ave Date signed 11/28/46

correct age is especially important. Physicians: please write plainly.

VS 150

X

G15829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G15829 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2632 Loyola Southway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 48 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2632 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Hecht

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Joseph Morganstern
13. Birthplace Austria

MOTHER
14. Maiden Name Yurah
15. Birthplace Austria

16 (a) Informant Joseph Hecht
(b) Address 2632 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-46 (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim
Location Wash. Blvd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Signature of registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1946 at 9.25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1946 to 11/22 1946 and that I last saw h[illegible] alive on 11/22 1946.

Immediate cause of death — Duration

General Caremonstosis
Due to Carcinoma of uterus & adnexa
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Argyle St Date signed 11/23/46

correct age is especially important. Physicians please write legibly.

VS 150

G15830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15830

PLACE OF DEATH:
1) Baltimore City, Maryland
2) Street address Rayner Ave
3) Hospital or institution West Baltimore General
4) Length of stay in hospital or inst. (yrs., mos., or days)
5) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 No Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Sigfried Kramer

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

(b) Name of husband or wife Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-1879

AGE: Years	Months	Days	If less than one day
67	11	19	hr. min.

8. Birthplace Germany (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Abraham

13. Birthplace Germany

14. Maiden Name Lelsie

15. Birthplace Germany

16 (a) Informant Irene Kramer

(b) Address 1631 No Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Kewitz Inc

(b) Address 1429 E Baltimore St Huntingtown Baltimore, Md

19 (a) 11-24-1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Nov. 1946, at 9:47 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Chas. M. Kammer, Jr. M.D. Medical Examiner.

Date signed 23 Nov. 1946

VS 151

B.C. B-60066

G15831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15831 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5604 Reedy Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy David

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23 1946

8. AGE: Years	Months	~~Days~~	If less than one day
			4 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Theodore David

13. Birthplace Baltimore

MOTHER 14. Maiden Name Catherine Bittrick

15. Birthplace Baltimore

16 (a) Informant Mother

(b) Address 5604 Reedy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore Co. Md.

18 (a) Funeral director H. W. Meardyson

(b) Address 845 N. Calvert St.

19 (a) 1946 (Registered by registrar) (b) Registrar

Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1946, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1946 to Nov. 23 1946 and that I last saw h[illegible] alive on Nov. 23 1946.

Immediate cause of death	Duration
Prematurity	
Due to Premature Labor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams M. D.

Address Mercy Hospital Date signed 11-23-46

X

G15832 BALTIMORE CITY HEALTH DEPARTMENT G15832
CERTIFICATE OF DEATH 1467
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 N Calvert St.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH GONSOLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1881

8. AGE: Years 65 Months 6 Days 20 If less than one day hr. min.

9. Birthplace France
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name JOSEPH GONSOLIN

13. Birthplace France

MOTHER 14. Maiden Name CELESTINE GONSOLIN

15. Birthplace France

16 (a) Informant JOSEPH Gaygan

(b) Address 1118 Brentwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 505 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/46 19 at 12 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1946, to 11/22 1946, and that I last saw h alive on 11/22 1946.

Immediate cause of death Respiratory Failure — Duration

Due to Cancer of rectum — 3 mos.

Due to

Other Conditions Eviseration - 10/18/46
(Include pregnancy within 3 months of death)

Date of operation 9/24/46

Major findings of operation: Colostomy Cancer of rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature August Kiel M. D.

Address Mercy Hospital Date signed 11/22/46

Direct age is especially important. Physicians please write clearly and legibly.

VS 150

D.L. 9-62741
G15833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G15833 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Calvert
(c) Hospital or institution: University 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jones - Barbara A. Jones

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9 AM 11/19/46

8. AGE: Years	Months	Days	If less than one day
0	0	4	____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Aubrey Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Vernice Clayton
15. Birthplace Va.

16 (a) Informant Aubrey Jones
(b) Address 1028 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Samuel M. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) 1946 (Date filed by registrar) (b) Huntington Williams, Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1946, 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1946, to 11/22 1946, and that I last saw her alive on 11/22 1946.

Immediate cause of death: Pneumonia — Duration
Due to: atelectasis
Due to: Prematurity
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/23/46

C15834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

C15837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Ba Howard
(c) City or town Rural Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Lawyers Hill (If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert G. Lowndes

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1888

8. AGE: Years 58 | Months 9 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Investment Banker
11. Industry or business Broker Founder

FATHER
12. Name Charles D. Lounder
13. Birthplace Virginia

MOTHER
14. Maiden Name Nannie Gamble
15. Birthplace Florida

16 (a) Informant: Miss Letitia W. Lounder
(b) Address Lawyers Hill Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19. Filed 11-25-1946 (b) (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1946, to Nov 24 1946, and that I last saw h alive on Nov 23 1946

Immediate cause of death: Coronary thrombosis — Duration: 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George T. Schlegel M.D.
Address 1 W 11th Date signed 11-25-46

Correct age is especially important. Physicians: please write out causes of death clearly and legibly.

5835 BALTIMORE CITY HEALTH DEPARTMENT C25835
CERTIFICATE OF DEATH 46a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 288 E Main (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar H Deal

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ida B. Matthews

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 6/26/71

8. AGE: Years 75 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state) Barnesville

10. Usual Occupation Ret'd

11. Industry or business

MOTHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 46 (month) (day) (year)
(c) Cemetery or crematory Westminster Md
Location Westminster Md.

18 (a) Funeral director J. F. Reese
(b) Address Westminster Md

NOV 25 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1946 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946 to Nov 29 1946 and that I last saw him alive on Nov 29 1946

Immediate cause of death Cachexia — Duration

Due to Cancer of Esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 13th 1946

Major findings of operation: Gastrostomy

of autopsy Cancer Esophagus

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Marshall M.D.

Address Date signed

I certify that the above statements are correct and complete to the best of my knowledge and belief. Physicians: please write plainly.

VS 150

D45836 BALTIMORE CITY HEALTH DEPARTMENT D45836
CERTIFICATE OF DEATH 53 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 EAST MONTGOMERY ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 E. MONTGOMERY (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDRICKA B. MITCHELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife WILLIAM MITCHELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 2, 1857

8. AGE: Years 89 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace RICHMOND, VA. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER 12. Name — ERHARDT
13. Birthplace GERMANY

MOTHER 14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant ROBERT MITCHELL
(b) Address 602 STONELEIGH RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 25 96 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) NOV 25 1946 for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 21, 1946 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/10/ 1945 to 11/21/ 1946 and that I last saw h-r alive on 4/21/ 1946.

Immediate cause of death Cardiac thrombosis — Duration 3 days
Due to arteriosclerosis — 3 yrs
Due to — 3 yrs
Other Conditions Carcinoma of Kidney
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. F. Hawkins M. D.
Address 1 E. Davis St. Date signed

correct age is especially important. Physicians: please write

VS 190

94a

G15837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G15837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 S. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. Chester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Mackiewicz also known as Anton Matzkevich

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-3563

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Josephine Mackiewicz 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state or foreign country)

10. Usual Occupation Balto. and Ohio R.R.

11. Industry or business

FATHER: 12. Name Mackiewicz
13. Birthplace Poland

MOTHER: 14. Maiden Name Ambrozewicz
15. Birthplace Poland

16 (a) Informant Mrs. Josephine Mackiewicz
(b) Address 226 S. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-46 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b)
Registrar's Signature
NOV 25 1946
VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 19 43 to Nov. 22 1946 and that I last saw h[illegible] alive on Nov. 23 1946

Immediate cause of death
(a) BRONCHOGENIC CARCINOMA, LEFT LUNG — Duration: AUG. 1946
Due to
Due to
Other Conditions HYPERTENSIVE - CARDIO-VASCULAR DISEASE — 10/25/43
(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: —
of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack F. Dranga
Address 209 S. Chester St Date signed M. 11 D. 23 Y. 46

correct age is especially important. Physicians: please write

5838 P.L.
9.62702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G15835 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 Sinclair Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magdalene Hipps 21 d

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/46

8. AGE: Years	Months	Days	If less than one day
			16 hr. 30 min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Henry Hipps
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Magdaline W. Hipps
15. Birthplace Balto Md

16 (a) Informant mother
(b) Address 2031 Sinclair Lane

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 22 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 25 1946 (Date rec'd by registrar) Hamilton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21/1946 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1946 to 11/21 1946.
and that I last saw him alive on 11/21 1946

Immediate cause of death: atelectasis — Duration

Due to: Premature Infant 5 months gestation

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas H. Richards M.D.
Address St. Joseph's Hosp Date signed 11/21/46

Correct age is especially important. Physicians please!

VS 150

X

G15839 B.C.
9-62703

BALTIMORE CITY HEALTH DEPARTMENT ✓ G15839 ✓
CERTIFICATE OF DEATH 159
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: Bon Secours St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 13 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 St. Clair Lane (If rural give location)
(e) Citizen of foreign country? Scotland (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hippes, Thomas Henry JR.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/46

8. AGE: Years	Months	Days	If less than one day
			6 hr. 30 min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Henry Hippes
13. Birthplace Balto Md

MOTHER
14. Maiden Name Magdalene W Berkowski
15. Birthplace Balto Md

16 (a) Informant Mother
(b) Address 2031 Sinclair Lane

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 22 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 25 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/46 19 , at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 19 46 to 11/20 19 46, and that I last saw h[illegible] alive on 11/20 19 46

Immediate cause of death	Duration
Atelectasis	
Due to (Premature Infant 5 mo. gestation)	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Mahon Jr. M. D.
Address St. Joseph's Hosp Date signed 11/24/46

correct age is especially important. Physicians: please write

VS 150

×

15810 G15810

B.C.G-62387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Susan Gaynor Mason

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-46

8. AGE: Years	Months	Days	If less than one day
		3 days	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, or state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Roland Byrd Mason
13. Birthplace Parkville, Md.

MOTHER
14. Maiden Name Yvonne Estelle Tomlinsin
15. Birthplace Darwen, England

16 (a) Informant Mother
(b) Address Towson, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 22 1946

18 (a) Funeral director
(b) Address Commissioner of Health

NOV 25 1946 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1946, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18-46 19 , to 11-21 1946, and that I last saw her alive on 11-21 1946.

Immediate cause of death atelectasis — Duration

Due to premature birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Santmyer
Address Franklin Sq Hosp Date signed 11/23/46

correct age is especially important. Physicians: please write plainly.

VS 180

G15811 BC# G62233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G15811 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Myrtle Ave.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Tyson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C.	

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1946

8. AGE: Years	Months	Days	If less than one day
		F	15' hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Charlie Davis
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lottie L. Tyson
15. Birthplace Rockyham, N.C.

16 (a) Informant Mother
(b) Address 508 Myrtle Ave.

17 (a) — (Burial, cremation, or removal) (b) Date thereof — (month) (day) (year)
(c) Cemetery or crematory —
Location University Medical School NOV 22 1946

18 (a) Funeral director Commissioner of Health
(b) Address —

NOV 25 1946 Huntington Williams M.D.
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1946, at 8 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946, to Nov. 20 1946, and that I last saw h[illegible] alive on Nov. 20 1946.

Immediate cause of death	Duration
Prema turity	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frank Phillips M.D.
Address 1542 Fenwick Ave. Date signed 11-20-46

G15812 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G15812

CERTIFICATE OF DEATH 467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Winston Ave Baltimore
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Leslie Fox

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife Paul Leslie Fox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1911

8. AGE: Years	Months	Days	If less than one day
35	5	10	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Liquor Sales Man
11. Industry or business

FATHER
12. Name Harry Christian Fox
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Caroline Shank
15. Birthplace Pennsylvania

16 (a) Informant: wife
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/26/46 (month) (day) (year)
(c) Cemetery or crematory Sharpe
Location Harrisburg Pa

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1946, to Nov 24 1946, and that I last saw h/s alive on Nov 24 1946.

Immediate cause of death Respiratory failure

Due to Post operative complications

Due to Pancreatic carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L Maer M. D.
Address Union Memorial Hosp. Date signed 11-27-46

correct age is especially important. Physicians: please write in ink or type. Be careful to spell names correctly and legibly.

VS 150 NOV 25 1946

Registrar Williams

G15813 ✓ BALTIMORE CITY HEALTH DEPARTMENT G15813 ✓
CERTIFICATE OF DEATH 181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital. 21
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Sargeant St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH E. BERTHOLOT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband Charles Berthold

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1902

8. AGE: Years 44 | Months 7 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William Kelly
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Conlon
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Elizabeth Greiting
(b) Address 603 Walbrook St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 25 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Nov. 1946, at 2 19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Nov 1946 to 23 Nov 1946, and that I last saw h~~e~~r alive on 23 Nov 1946.

Immediate cause of death	Duration
BURNS, ACCIDENTAL, 1st & 2nd DEGREE, TRUNK	
Due to AND EXTREMITIES	4 DA.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 21/2
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 19 Nov '46 at 9 20 A.M.
(c) Where did injury occur? BALTO. (City or town), BALTO. (County), MD. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? Y es.
(e) Means of injury? IGNITED CLEANING FL. on CLOTH.

23. Signature Howard J. Williams M.D.
Address Franklin Square Hosp. Date signed 23 Nov.

Howard J. Williams, M.D. X 6896

Huntington

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G15844 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2835 N Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 2835 N Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Lovell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida M Lovell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20 1866

8. AGE: Years	Months	Days	If less than one day
80	0	3	hr. min.

9. Birthplace West minster Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John N Lovell
13. Birthplace West minster Md

MOTHER
14. Maiden Name Hooker
15. Birthplace Westminster Frd Md

16 (a) Informant Mrs Ida M Lovell
(b) Address 2835 N Lanvale St

17 (a) Burial Date thereof 11/26/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1946 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1946 to Nov 23 1946, and that I last saw h Pt alive on Nov 23 1946

Immediate cause of death Myocardial insufficiency Duration
arteriosclerotic heart disease
with congestive failure. 1 day
Due to Generalized arterio sclerosis, Hypertension 5 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W-Nuckel M. D.
Address 2901 Edmondson Date signed Nov 23 46

correct age is especially important. Physicians: please write plainly.

VS 150 NOV 25 1946 Registration District No.

G15815
CMK-106073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ ✓ G15815 Registered No. 137a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Adam Kraft

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20-1900

8. AGE: Years	Months	Days	If less than one day hr.	min.
45	7	2		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

PARENTS
12. Name George Kraft
13. Birthplace Maryland
14. Maiden Name Annie Williams
15. Birthplace West Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Rd.

18 (a) Funeral director Edward Foulger
(b) Address 2319 Wash. Blvd.

19 (a) (Date rec'd by Registrar) (b) Registrar
NOV 25 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH November 22 19 46, at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 19 46 to Nov. 22 19 46, and that I last saw him alive on Nov. 22 19 46.

Immediate cause of death Uremia — Duration

Due to Renal insufficiency

Due to Prostatic hypertrophy and carcinoma of bladder.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/14/46

Major findings of operation: Prostatic hypertrophy

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Gibbs M. D.
Address Balto. City Hosp. Date signed 11/27/46

X

correct age is especially important. Physicians: please write

G15816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: So Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 E Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Reva Seigle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex ● F | 5. Color or race W | 6 (a) Single, married, widowed or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1872

8. AGE: Years 74 | Months 7 | Days | If less than one day hr. min.

9. Birthplace R-SSIA (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Raman

13. Birthplace Russia

MOTHER 14. Maiden Name Sala Dash-

15. Birthplace Russia

16 (a) Informant Newman R. Seigle

(b) Address 452 M. St., S.W., Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Woodland

Location

18 (a) Funeral director Jack Levine Inc

(b) Address 1431 E. Baltimore St

19 (a) (Date rec'd by registrar) Washington Metropolitan

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1946, to 11-24 1946, and that I last saw her alive on 11-24 1946.

Immediate cause of death	Duration
Myocardial Infarction	
Due to Coronary occlusion	
Due to Coronary arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Swinfell MD, M. D.

Address 1211 Light St. Date signed 11-24-46

correct age is especially important. Physicians: please write the

VS NOV 25 1946

G15817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G15817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Schroeder Ave. Sheen Spring 6-4
(c) Hospital or institution: LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town.)
(d) Street No. 1619 E Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNY SCHILLER (SHILLER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1867

8. AGE: Years 79 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Solomon

13. Birthplace Russia

14. Maiden Name Frieda

15. Birthplace Russia

16 (a) Informant Mrs. Pauline Morgan

(b) Address 1619 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-46 (month, day) (year)

(c) Cemetery or crematory Hebrew Rit Cemetery

Location

18 (a) Funeral director Yaffe Funeral Dir.

(b) Address 1731 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1946 at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1946 to 11-24 1946 and that I last saw h alive on 11-24 1946

Immediate cause of death: Chronic cardio vascular disease

Due to: Hypertension Mitral regurgitation

Due to: Hydrothorax

Other Conditions: Hydrothorax

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Vogel M. D.

Address Levindale Date signed 11-24-46

VS 100

correct age is especially important. Physicians: please write the

G15818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G15818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Mayfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Mayfield Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Wm Cooper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced divorced

6 (b) Name of husband or wife Mary L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 - 1863

8. AGE: Years 83 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Silas Cooper

13. Birthplace Penna.

MOTHER 14. Maiden Name Elizabeth Martin

15. Birthplace Penna

16 (a) Informant Mrs. Chas. A. Seht

(b) Address 2401 Mayfield Ave

17 (a) Removal (b) Date thereof 11 26 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Hill

Location Millersburg Penna

18 (a) Funeral director Philip Herring Sons

(b) Address 2024 Orleans St

19 (c) NOV 29 1946 (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1946, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946, to Nov 24 1946, and that I last saw him alive on Nov. 23 1946.

Immediate cause of death — Duration

My condition 1 yr.

Due to

Due to

Other Conditions Cardiac Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Frahm M. D.

Address 182 N. Washington Ave Date signed 11/26/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 190

G15819 ✓ G15819 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 7
(c) City or town Baltimore - 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Grindon Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward (Swarty) Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4224

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Alberta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/26/1901

8. AGE: Years	Months	Days	If less than one day
44	11	29	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation refrigerator repair
11. Industry or business

FATHER
12. Name Edward F. Schwartz
13. Birthplace Germany

MOTHER
14. Maiden Name Anna E. Richard
15. Birthplace Balto Md.

16 (a) Informant Mrs. E. N. Schwartz
(b) Address 2814 Grindon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory Immanuel
Location Balto Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd

19 (a) NOV 25 1946 (b) Registrar Huntington Hitchcock

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 1946, at 12 N

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1946 to 11/24 1946, and that I last saw h[illegible] alive on 11/24 1946.

Immediate cause of death	Duration
Metastatic Brain Abscess	2 days
Due to Pulmonary Tuberculosis Bilateral - Far Advanced	20 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C Morrow
Address University Hosp. Date signed 11/24/46 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G15859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome De Francis

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-3145

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Genevieve

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 1886

8. AGE: Years	Months	Days	If less than one day
60	1	17/16	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Rocco De Frances

13. Birthplace Italy

MOTHER 14. Maiden Name Cristina Simeone

15. Birthplace Italy

16 (a) Informant Genevieve De Frances (Wife)

(b) Address 3511 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26 1946 (month) (day) (year)

(c) Cemetery ~~or Crematory~~ Holy Redeemer Cem.

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 98 N. Gorley St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

NOV 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 1946, at 8:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertension Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William F. Kelly M.D. (Medical Examiner.)

Date signed 23 Nov 46

G15851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G15851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Dukeland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Dukeland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM N. BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha Ann Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1868

8. AGE: Years	Months	Days	If less than one day
78	10	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Pipe Fitter
11. Industry or business

FATHER
12. Name Wm. R. Brown
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Va. Sangston
15. Birthplace Md.

16 (a) Informant Mrs. Martha A. Brown
(b) Address 1102 Dukeland St.

17 (a) Burial (b) Date thereof 11/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by Registrar) (Registrar)

NOV 28 1946

Correct age if impossible to secure exact figures. Approximate ages are acceptable.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1946 at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1944, to Nov 23 1946, and that I last saw him alive on Oct 3 1946.

Immediate cause of death Coronary Thrombosis -
Duration Hours
Due to Coronary Sclerosis -
Due to
Other Conditions Hemiplegia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D McCarty M. D.
Address 27 W Preston St Date signed 11/29/46

Form 950

X

G15852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936 E

Registered No. G15852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 Hilliard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 Hilliard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth V. Leach — Leach —
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife John W.
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) 7 Jan. 1907
8. AGE: Years 39-29 | Months 10 | Days 15 | If less than one day hr. min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Home wife
11. Industry or business At Home

FATHER
12. Name Charles A. Austin
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Jones
15. Birthplace Maryland

16 (a) Informant Mrs. Louise H. Leach
(b) Address 141 Hilliard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 25 Nov 46 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City - Md.

18 (a) Funeral director H. B. Shipley & Son
(b) Address 1300 Eutaw Pl.

19 (a) 25 Nov 1946 (Date received by Registrar) (b) [illegible]

Huntington Hilliard

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov. 1946, at 7 P.M.

21. I certify that death occurred on the date above stated; that attended deceased from May 22 1946, to Nov 22 1946, and that I last saw h[illegible] alive on Nov 22 1946.

Immediate cause of death

	Duration
Acute Cardiac Dilatation	Ab. day
Due to Hypertension	3
Due to	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry Grossman M. D.
Address 25 3 Mt Royal Date signed 7 Dec 46

Correct age is especially important. Physicians: please write plainly. Strike the word not applicable.

NOV 2 1946

15853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47c

Registered No. G15853 ✓

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 E. University Parkway
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E. University Pkwy.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CLEMENT WARNER HOLLINGSWORTH

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-09-5105

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife: Edna L. Hollingsworth
6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1889

8. AGE: Years	Months	Days	If less than one day
57	9	15	hr. ___ min.

9. Birthplace: Pleasantville, Md. (Town, county, and state)
10. Usual Occupation: Salesman
11. Industry or business: Coal Business

FATHER
12. Name: Cyrus Clement Hollingsworth
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden Name: Virginia Russell Hanway
15. Birthplace: Harford Co. Md.

16 (a) Informant: Mrs. Edna Long Hollingsworth
(b) Address: 201 E. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory: Friends Cemetery
Location: Old Harford Road

18 (a) Funeral director: Chas. J. Graves & Son, Inc.
(b) Address: 118 N. Mt. Royal Ave.

NOV 25 1946 Huntington Williams M.D.
(Date and delivered) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1946 to Nov 23 1946.
and that I last saw h alive on Nov 22 1946.

Immediate cause of death: Bronchogenic Carcinoma with Pul Hemorrhage — Duration

Due to

Due to

Other Conditions: Arrested Pul Tb.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Huntington Williams
Address: 104 W. Mulberry St Date signed: Nov 25 1946

correct age is especially important. Physicians: please write

VS 150

X

G15851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G15851 V

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 N. Luzerne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 N. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GETTY INGLART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Philip Inglart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/80

8. AGE: Years	Months	Days	If less than one day
66	9	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Everett
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Rose Causey - daughter
(b) Address 925 N. Luzerne Avenue

17 (a) Burial (b) Date thereof 11/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by Registrar) NOV 26 1946 (Registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV-22 1946, at 11:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946, to NOV 22 1946, and that I last saw her alive on NOV 21 1946.

Immediate cause of death
Myocardial Failure — Duration 11/20/46 — 1 year
chronic myocarditis
Due to arterio + s clerosis — 10 yrs
Due to —
Other Conditions Arthritis Deformans — 10 yrs
Parkinsonian disease
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Paul F. Cummerman M. D.
Address 722 N. Kenwood Ave. Date signed 11/26/46

correct age is especially important. Physicians: please write plainly. Give the causes of death clearly and legibly.

B.C.J. 62767

G15855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 159

G15855 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6Hrs 5Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk - 22, - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Sollars Point
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/21/46

8. AGE: Years	Months	Days	If less than one day
			6 hr. 5 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Francis Redmond
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Marie Helen Cook
15. Birthplace Baltimore Md.

16 (a) Informant Parents
(b) Address 2900 Sollers Point Rd.

17 (a) Burial (b) Date thereof 11/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell Street

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison St.

19 (a) NOV 25 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21/46 19 at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21-46 19 , to 11-21 19 46, and that I last saw him alive on 11-21 19 46.

Immediate cause of death — Duration

Cardio-respiratory failure

Due to Prematurity (7 mos)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp. Date signed 11-22-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

for Williams, M.D.

P.C.-g.-62766

G15956

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or institution (yrs., mos., or days) 1 Day 9 Hrs. 25 Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk - 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Sollers Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Jane Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/21/46

8. AGE: Years	Months	Days	If less than one day
		1	9 hr. 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Francis Redmond
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Marie Helen Cook
15. Birthplace Baltimore Md.

16 (a) Informant Parents
(b) Address 2900 Sollers Point Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] 11/26/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location O'Donnell Street

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23-46 19 2:35 A.M. at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21/46 19 to 11/23/46 19, and that I last saw h. da alive on 11/23/46 19

Immediate cause of death: cardio - respiratory — Duration:

Due to prematurity - 7 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. H. Worth Jr. M. D.
Address Bon Secours Hosp. Date signed 11/23/46

VS 150 NOV 25 1946

[illegible] Williams, M.D.

G15857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

Registered No. G15857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5023 Frederick Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 5023 Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Robert Yewell

3 (b) If veteran, name war: I World War

3 (c) Social Security Account No. 215-10-[illegible]

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie L. Flynn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 12. 1898

8. AGE: Years 49 | Months 8 | Days 10 | If less than one day: hr. min.

9. Birthplace: Phoenix Balto. Co. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Carpenter Shop Bricklayer

FATHER
12. Name: John A. Yewell
13. Birthplace: Boyleville, Worcester Co. Md.

MOTHER
14. Maiden Name: Margaret A. Hood
15. Birthplace: Frederick, Md.

16 (a) Informant: Mrs. Elsie L. Yewell
(b) Address: 5023 Frederick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-46 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat. Cem.
Location: Baltimore Md.

18 (a) Funeral director: Lorman Byers
(b) Address: 505 Pk Ave

19 (a) (b)

NOV 25 1946

Huntington Hill Register

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1946 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1946 to Nov 22 1946, and that I last saw h[illegible] alive on Nov 22 1946.

Immediate cause of death: Pulmonary embolus — Duration: 1 hour
Due to: Thrombophlebitis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Harry A. McCarty
Address: 37 W. Preston St Date signed: M. 11 D. 24/46

X

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

G15858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

G15858

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 N. Carrollton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Hall Chapman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband/or wife/ William A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/1898

8. AGE: Years	Months	Days	If less than one day
48	2	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Emory Hall
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Carrie Brown
15. Birthplace Calvert Co. Md

16 (a) Informant William A. Chapman (H)
(b) Address 308 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md

18 (a) Funeral director Charles J. Cooper
(b) Address 510-12 Carrollton Ave

19 (c) [illegible] Huntington Williams, M.D.

NOV 25 1946

MEDICAL CERTIFICATION F

20. DATE OF DEATH 11/21/46 19 , at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1946 to 11/21 1946 and that I last saw h[illegible] alive on 11/21 1946

Immediate cause of death
Hypertension Cardio
Renal Vascular

	Duration
Due to	
Due to	7 Days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. O. Chatham
Address 1 W. Ks Parkside Date signed 11/25/46

correct age is especially important. Physicians: please write

VS 150

X

G15859 **BALTIMORE CITY HEALTH DEPARTMENT** G15859
CERTIFICATE OF DEATH 1310 **Registered No.**

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 S. Wickham (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Doran

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 29-1887

8. AGE: Years 59 | Months 7 | Days 25 | If less than one day ___ hr. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Weighter

11. Industry or business Chambers of Commerce

FATHER
12. Name John Doran
13. Birthplace Vermont?

MOTHER
14. Maiden Name Margaret Doyle
15. Birthplace Balto. Md

16 (a) Informant Harry J. Doran
(b) Address Edgewood Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26-46 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Collins & Gilmor Sts.

19 (a) NOV 25 1946 (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION 8

20. DATE OF DEATH Nov. 23, 1946, at 9.20 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/23/46

G15850

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 152B

G15850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N. Carey ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	

6 (b) Name of husband or wife Mary Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-21-1880

8. AGE: Years	Months	Days	If less than one day
65 66	11	2	hr. min.

9. Birthplace Baltimore, Md (Town, county and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Brooks
(b) Address 1019 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Mrs. G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

Nov 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1946, at 6 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-27 1946, to 11-23 1946, and that I last saw h[illegible] alive on 11-23 1946.

Immediate cause of death Pulmonary Embolism — Duration

Due to Carcinoma of Urinary Bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-26-46

Major findings of operation: Carcinoma of U. Bladder

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Jackson / J. Mulatto M.D.
Address 1514 Division St Date signed 11-23-46

correct age is especially important. Physicians: please write the c[illegible]

G15861 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 15861

CERTIFICATE OF DEATH

1937

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G15862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15862 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town ~~Baltimore~~ Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rogers Ave. -Ellicott City
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H L. TEMFIELD

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19, 1882

8. AGE: Years 63 Months 11 10 Days 5 25 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Geo. Litchfield

13. Birthplace md.

MOTHER 14. Maiden Name Eliz. Brown

15. Birthplace md

16 (a) Informant Mrs Helen Litchfield

(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)

(c) Cemetery or crematory St Marks

Location Highland md

18 (a) Funeral director J. C. Higinbotham

(b) Address Ellicott City md.

19 (a) [illegible] Washington Boulevard

NOV 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1946, at 2.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured pelvis
Fractured right femur
Fractured rt. tibia and fibula
Due to:
Intracranial hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-23-46 Howard Co. 8 P. M.
(b) Where did injury occur? Rogers Ave. Rt. #40
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/25/46

VS 101

G15863 G15863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Robert St.
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 Robert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Hasty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1884

8. AGE: Years	Months	Days	If less than one day
62	6	12	hr. min.

9. Birthplace Monroe, N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mark Miller
13. Birthplace Monroe, N. C.

MOTHER
14. Maiden Name Nellie ???
15. Birthplace

16 (a) Informant Mrs Hasty
(b) Address 526 Robert St.

17 (a) Burial (b) Date thereof Nov. 25 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Rev. Geo. A. Hollan
(b) Address 1631 Druid Hill Ave

(c) Date rec'd by registrar NOV 25 1946 (d) Registrar's signature for William Spiller

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1946, at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1946 to Nov. 22 1946 and that I last saw h. alive on Nov. 22 1946

Immediate cause of death: Carcinoma of Urinary Bladder — Duration 2 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Shipley

Address 1543 Eleanor Ave Date signed 11/25/46

copper age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15864 — BALTIMORE CITY HEALTH DEPARTMENT — G15864 Registered No.

CERTIFICATE OF DEATH 86-a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 S. Paca Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MICHAEL YESKANSHAS

3 (b) If veteran, name war: Yes
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 29 1895
8. AGE: Years 51 50 | Months 1 | Days 25 | If less than one day hr. min.
9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name M. Kuzmuckas
13. Birthplace Lithuania

MOTHER
14. Maiden Name Magdalena ?
15. Birthplace Lithuania

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nath. Cem.
Location 501 Frederick Rd.

18 (a) Funeral director Joseph Kasmakas Inc.
(b) Address 602 Washington Blvd
NOV 25 1946 (Date rec'd by registrar) (b) Huntington Williamson, Md.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 19 46 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Intracranial hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-23-46. 7. 15 a. M.
(b) Where did injury occur? 424 S. Paca St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down stairs

23. Signature George B. Merrill M.D. Medical Examiner.
Date signed 11/23/46

X

G15865 G15865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 739 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 739 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Paul Waitekunas

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-01-9319

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
76 ?			hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Christopher Mikolaitis
(b) Address 739 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-37 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kasinskas
(b) Address 608 Wash. Blvd

19 (a) 12-1-1937 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1937 at 1 CP M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/22 1937 to 11/24 1937 and that I last saw h[illegible] alive on 11/24 1937

Immediate cause of death	Duration
Arteriosclerotic cardiovascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Pickett M.D.
Address 1101 St. Paul Date signed 11/27/37

Neglect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15866 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Hanover ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Hanover ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Wirth

3 (b) If veteran, name war

3 (c) Social Security Account No. 242-01-2982

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia E. Wirth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3, 1884

8. AGE: Years	Months	Days	If less than one day
62	10	22	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Federal Housing

FATHER
12. Name John P. Wirth
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Sauers
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Julia E. Wirth
(b) Address 2910 Hanover ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor ave

18 (a) Funeral director Howard M. Bright Jr.
(b) Address 6009 Harford Road.

NOV 25 1946 (c) Date received by registrar (d) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 November 1946, at 8 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5 June 1946 to 25 Nov. 1946; and that I last saw him alive on 20 Nov. 1946.

Immediate cause of death Coronary Occlusion — Duration Undetermined

Due to Arteriosclerotic Cardio-vascular Disease, Generalized. — Undetermined

Due to — Undetermined

Other Conditions Hypertension moderately severe, Secondary Wedge — Undetermined
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence, at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Thal M.D.
Address 7329 Harford Rd. Date signed 25 Nov 46.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G15867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 N Elwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. Endres

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Charles J.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 2, 1885

8. AGE: Years	Months	Days	If less than one day
61	4	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Eligius Von Parris
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Dietz
15. Birthplace Baltimore, Md.

16 (a) Informant Charles J. Endres
(b) Address 1331 N. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Pine Sts.

19 (a) NOV 25 1946 Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946, at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hypertension Cardiac Insufficiency
disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelbach M.D. Medical Examiner
Date signed 24 Nov 46

G15838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

G15868 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (~~hours or~~ days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. John Redel

3 (b) If veteran, name war

3 (c) Social Security Account No. 24-01-9948

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs Frances Redel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1881

8. AGE: Years	Months	Days	If less than one day
65	1	24	hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual Occupation Asbestos Worker
11. Industry or business Armstrong Corks

FATHER
12. Name Andrew Redel
13. Birthplace Germany

MOTHER
14. Maiden Name Margard Raab
15. Birthplace Not known

16 (a) Informant Mrs Frances Catherine Redel
(b) Address 1624 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cemetery
Location Fallston Md.

18 (a) Funeral director Edmund W. Cashman Sons
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md

NOV 25 1946

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1946 to Nov 24 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Intestinal Obstruction	
Due to Ventral Hernia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/23/46
Major findings of operation Ileostomy Enteroenterostomy
of autopsy Obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian Jamorski M. D.
Address 11 So. Hoyt Date signed 11/24/46

X

Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.

G15869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G15869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Robert Cauble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1926

8. AGE: Years	Months	Days	If less than one day
20	10	2	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business John Fuerher

FATHER
12. Name Fletcher L. Cauble
13. Birthplace North Carolina

MOTHER
14. Maiden Name Jessie Leah Russel
15. Birthplace North Carolina

16 (a) Informant Mrs. M. Wright Cooper
(b) Address 1604 East 29th Street

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory Chestnut Hill
Location Salisbury, North Carolina

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date received 11-25-1946 (b) Filed

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1946, at 4.50P M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic heart disease, with aortic valvulitis, and

Due to hypertrophy and dilatation of left ventricle,

Other Conditions Acute Congestion of all organs,

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/25/46

G15870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G15870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Sunberry (If outside limits of town write RURAL and give town)
(d) Street No. 249 Walnut Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Werline

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel Werline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 15 1865

8. AGE: Years: 81 Months: 8 Days: 9 If less than one day: hr. min.

9. Birthplace: Montandon Pa. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business:

FATHER
12. Name: Amos Horner
13. Birthplace: Pa

MOTHER
14. Maiden Name: Sarah Buchheit
15. Birthplace: Pa

16 (a) Informant: Mrs. Haley Mutzer
(b) Address: Sunbury Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/46 (month) (day) (year)
(c) Cemetery or crematory: Sunbury
Location: Sunbury Pa

18 (a) Funeral director: Wilbur Lutz Inc
(b) Address: 1217 St Paul St

19 (a) NOV 25 1946 (Date filed by registrar) (b) Registrar, Baltimore, Md.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1946, at 1 a.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 16, 1946- about 12 P.M.
(b) Where did injury occur? 3484- Charles Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down flight stairs

23. Signature George F. Merrill, Medical Examiner
Date signed 11/25/46

G15871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15871 V

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 DA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 North Charles
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS K. OWINGS

3 (b) If veteran, name war: Spanish American War Veteran
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Myra R. Owings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4 1874

8. AGE: Years	Months	Days	If less than one day
72	8	20	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired Government Engineer
11. Industry or business

FATHER
12. Name Henry M. Owings
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lizzie M. Richardson
15. Birthplace Balto Md

16 (a) Informant Mrs Myra R. Owings
(b) Address 2224 N. Charles St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 26 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Baltzer & Pot
(b) Address 2224 N. Charles St.
(c) Huntington Williams M.D.

NOV 25 1946
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/46 19 at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner
Date signed 11/24/46

G15872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15872 Registered No. L

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3709 - 5th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 - 5th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline C. Hines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Frank Hines

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23 1867

8. AGE: Years	Months	Days	If less than one day
79	- 3	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Anton Oppel

13. Birthplace Germany

14. Maiden Name Amelia Heisenhelder

15. Birthplace Germany

16 (a) Informant Miss Marie Hines

(b) Address 3709 - 5th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Gor Ritchie Highway
Mitchell Shelby

18 (a) Funeral director

(b) Address 3914 Hanover St 25

19 (a) (Signature and address of local registrar)

NOV 25 1946

Huntington Williams

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1946, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 46 to Nov 23 1946, and that I last saw h[illegible] alive on Nov 23 19 46.

Immediate cause of death

Chronic hypertrophic cirrhosis — Duration 18 mo.

Due to arteriosclerosis — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature D. J. Imraldi M. D.

Address 4609 Gor. Ritchie Hwy Signed 11-25-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G15873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 E. Madison st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 E Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Mary Christian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Nelson Christian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation
11. Industry or business Domestic

FATHER
12. Name Daniel Davis
13. Birthplace Va

MOTHER
14. Maiden Name Jennie Randolph
15. Birthplace Va

16 (a) Informant Nelson Christian Husband
(b) Address 1809 E Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 25. 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Lawn Cemetery
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1600 Pitcher St

19 (a) NOV 25 1946 (b) Huntington Williams Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 at 1946 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Nov 24 1946 and that I last saw him alive on Nov 20 1946.

Immediate cause of death: Cerebral Hemmorrhage — Duration 3 days
Due to: Coronary embolism
Due to:
Other Conditions: Generalized arterio-sclerosis Hypertension and Chronic Nephritis — Complications
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ralph J. Young, M.D.
Address 1424 E Monument Date signed 11-23-46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

94a

G15871

Dr. 106143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15871

Registered No.

1860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Prince Georges
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Utah Ave Brentwood, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary DeGonzales

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19th 1882

8. AGE: Years 64 Months 9 Days 6 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Bolin
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Cookran
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospital
(b) Address 4940 Eastern Ave (Records)

17 (a) Removal (Burial, cremation or removal) (b) Date thereof 11-27-46 (month) (day) (year)

(c) Cemetery or crematory Va.
Location

18 (a) Funeral director J. F. Crosby
(b) Address Fairfax, Va.

19 (a) NOV 25 1946 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25th 1946 at 1.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16th 1946 to Nov. 25th 1946, and that I last saw h.97 alive on Nov. 25th 1946

Immediate cause of death: Cerebral Thrombosis — Duration 9 days

Due to

Due to

Other Conditions Fracture - neck of left femur.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 16th 1946 ? M
(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Walking from bathroom to kitchen

23. Signature Thomas M. Lacy
Address Baltimore City Hosp. Date signed 11-25-46 M. D.

VS 150 (For Medical Examiner's Approval) Howard J. Mercer, M. D. X

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G15875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G15875

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 S. Poca Hontas St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1873

8. AGE: Years	Months	Days	If less than one day
73	—	—	hr. min.

9. Birthplace Balto. Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John E. Thomas
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Laura Wilson
15. Birthplace Cambridge, Md

16 (a) Informant Mary E. England
(b) Address 1502 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Ralph C. P. M. Walter
(b) Address Ralph's Chuckey Md

19 (a) NOV 25 1946 (Date received by registrar)
Huntington Williams, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1946, at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11, 1946 to Nov. 24 1946, and that I last saw h/ alive on Nov. 24 1946

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Malignancy of liver	1 yr.
Due to	
Other Conditions Syphilis - latent Arteriosclerosis - Moderate C-Hrt.	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas E. Thomas M.D.
Address Mercy Hosp. Date signed 11/24/46

G15876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G15876 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5203 Tramore Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Severna Pk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEREMIAH F. KEEFE (Jerrey O'Keeffe)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Mary Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2-1871

8. AGE: Years 75 | Months 1 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation Storekeeper
11. Industry or business

FATHER
12. Name Dennis Keefe
13. Birthplace Conn

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. C. F. Bauer
(b) Address 5203 Tramore Rd

17 (a) Burial (b) Date thereof 11-26-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) ____ (b) ____
(Date rec'd by registrar)

NOV 25 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 23 | 46 19 , at 10:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weirs M.D.
Medical Examiner
Date signed 11-27-46

Dr/ Pessagno

BALTIMORE CITY HEALTH DEPARTMENT

2314 E. Baltimore St. **CERTIFICATE OF DEATH** 48 B

Registered No. C 15977

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Evergreen Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Evergreen Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Stampone

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Nicholas Stampone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1883

8. AGE: Years	Months	Days	If less than one day
63	9	14	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Nicholas Valentino
13. Birthplace Italy

MOTHER
14. Maiden Name Elizabeth Poreca
15. Birthplace Italy

16 (a) Informant Mr. Nicholas Stampone
(b) Address 2702 Evergreen Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23, 1946 to Nov. 23 1946, and that I last saw her alive on Nov. 21, 1946

Immediate cause of death: Carcinoma - Uterus — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eugene D. Pessagno M. D.
Address 514 Drury Lane Date signed 11/23/46

VS 130 NOV 25 1946 Registrar, M.P.

G15878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15878 Registered No. 1314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 43d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3527 Lyndale Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Ann Deaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Orson W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 - 1891

8. AGE: Years 55 Months 4 Days 17 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis P. Klein
13. Birthplace Md.

MOTHER
14. Maiden Name Augusta L. O'Shea
15. Birthplace Md.

16 (a) Informant Mr. Orson W. Deaver
(b) Address 3527 Lyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Keck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1946, at 10.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1946 to 11/23 1946, and that I last saw h[illegible] alive on 11/23 1946.

Immediate cause of death: Cardio Respiratory Failure
Due to Hypertension C V Disease
Due to Nephritis. Chronic Glomerulo-nephritis
Other Conditions Broad ligament.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M. D.
Address St Josephs Hosp. Date signed 11/23/46

Form VS 190 Nov 25 1908 to Williams, M.D.

FORM MUST BE FILLED IN WITH INK. Use black ink and write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

5879 5879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

G15879
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEVEN MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 22 1946

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 22 1946 Thurlington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1946, 2.50 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral thrombosis
Cirrhosis of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 11/6/46

VS 181

Spec.—2-21-33—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G15880 **CERTIFICATE OF DEATH** ✓13B G15880

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3652 Ellerslie Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME (Mrs) Lenfield Coston Erb 93

(a) RESIDENCE NO. 3652 Ellerslie Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Henry Erb

6 DATE OF BIRTH (month, day, and year) March 10, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Coston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Howard H. Erb

(Address) 3652 Ellerslie Ave.

15 Filed NOV 25 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1946

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 19 46, to Nov 23, 19 46, that I last saw her alive on Nov 23, 19 46, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1? yrs. + mos. da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1- mos. 14 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) F. V. D. Mack, M. D.

, 19 (Address) 513 E. 39th St SX

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL 11/27 19 46

20 UNDERTAKER Wm. J. Fichner & Son — ADDRESS 2nd & Ellerslie Ave

G15931 D.L. 9-4-63010 Dr Burbaugh

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G15931 Registered No.

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air - Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Barnes St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Reel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/46

8. AGE: Years	Months	Days	If less than one day
		2	4 hr. min.

9. Birthplace Belton, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard DeWitt Reel
13. Birthplace Fawn Grove Pennsylvania

MOTHER
14. Maiden Name Eunice Mary Wilderson
15. Birthplace Finkesburg Md.

16 (a) Informant Richard D Reel
(b) Address Bel Air Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24/46 (month) (day) (year)
(c) Cemetery or crematory Bel Air Rolling Road
Location Bel Air, Md

18 (a) Funeral director Dean & Faber
(b) Address Bel Air Md

19 (a) Filed by (Signature of registrar) Huntington Williams M.D. Registrar

NOV 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946, at 6 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1946, to 11-25 1946, and that I last saw him alive on 11-25 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cerebral Hemorrhage	
Due to Diffuse Brain Extravasation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Faber M. D.
Address Bon Secours Hosp. Date signed 11-26-46

X

Dr. A. Himelfarb
1801 Eutaw Pl.

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. C35882

CERTIFICATE OF DEATH

C35882 V 186a

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Snyder's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Lawnview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Osterhaus

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1874

8. AGE: Years	Months	Days	If less than one day
72	8	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Osterhaus
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Busch
15. Birthplace Balto. Md,

16 (a) Informant Mr. William J. Osterhaus
(b) Address 4211 Willshire Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Signature) Huntington Williams, M.D.
(Date rec'd) NOV 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th, 1946, at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1946 to Nov 24 1946 and that I last saw h. alive on Nov. 21 1946

Immediate cause of death
Broncho pneumonia — Duration 5 wks.

Due to

Due to

Other Conditions
Fracture of r. femur
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/2
(a) Accident, suicide, or homicide accidental
(b) Date of occurrence Oct 14, 1946 at M
(c) Where did injury occur? Balto Md - 4700 Harford Rd
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Institution While at work? no
(Specify type of place)
(e) Means of injury Stumbled & fell to floor
23. Signature Albert J. Himelfarb
Address 1801 Eutaw Pl Date signed 11/25/46

Howard J. Mercer, M. D.

G15883 BALTIMORE CITY HEALTH DEPARTMENT X G15883
Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Brightwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Berlin
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella C. Burbage

3 (b) If veteran, name war:
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William J. Burbage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 17, 1865

8. AGE: Years 81 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace: Berlin, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Jesse Turner
13. Birthplace: England

MOTHER
14. Maiden Name: Katherine Griffith
15. Birthplace: Unknown

16 (a) Informant: Mrs. John F. Meyer
(b) Address: 3201 Brightwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28, 1946 (month) (day) (year)
(c) Cemetery or crematory: Evergreen Cemetery
Location: Berlin, Md.

18 (a) Funeral director: Charles Lamborn
(b) Address: 1005 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1946 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1946 to 11-25 1946 and that I last saw h[illegible] alive on 11-24 1946.

Immediate cause of death: Myocardial Failure — Duration
Due to: Hypertensive Arteriosclerosis
Due to: Chronic Nephritis
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Thos. F. Abbott M. D.
Address: 4509 Liberty Heights Ave. Date signed: 11-25-46

PLEASE WRITE PLAINLY. Physicians: please, write the causes of death clearly and legibly. Be sure the correct age is especially important.

VS 180

G15881 G15881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4W
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 941 W. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mack E. Heath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1883

8. AGE: Years	Months	Days	If less than one day
63	8		hr. min.

9. Birthplace Disputanta Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Heath

13. Birthplace Prince George Co. Va

MOTHER 14. Maiden Name Harriet Dee

15. Birthplace Prince George Co. Va.

16 (a) Informant Ernest Jackson

(b) Address 641 W. Redwood St.

17 (a) Disposal (Burial, cremation, or removal) (b) Date thereof Nov 25 1946 (month) (day) (year)

(c) Cemetery or crematory Petersburg Va.

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 822 N. Schroeder St

19 (a) Date received (Registrar) Huntington Williams M.D.

NOV 26 1946

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1946, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an inspec. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer S. Cheatham M.D.
Medical Examiner.
Date signed 11/24/46

G15985 BCH F5272 | BALTIMORE CITY HEALTH DEPARTMENT | G15985
CERTIFICATE OF DEATH 14
Registered No.

PRINT WRITE PLAINLY, with unfading ink. Do not use pencil. Do not abbreviate. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Pennsylvania (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sherwood Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-1942

8. AGE: Years	Months	Days	If less than one day
4	4	15	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sherwood Cooper
13. Birthplace Md.

MOTHER
14. Maiden Name Leonora Tyler
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Baltimore, Co. Md

18 (a) Funeral director Mrs. Frances A. Hennly
(b) Address 578 W. Biddle St

19 (a) (Date rec'd by Registrar) (b) Filing Number

NOV 26 1946 Huntington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946, to Nov. 22 1946 and that I last saw him alive on Nov. 22 1946.

Immediate cause of death	Duration
Tuberculosis Meningitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Kingsley M. D.
Address Johns Hopkins Hospital Date signed 11-25-46

X

5886 D.C. G-45886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160c

Registered No. G15886

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hours

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Maryland (b) County Howard
(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 1 Box 109
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Coward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20, 1946

8. AGE: Years | Months | Days | If less than one day: 2 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Claude Coward
13. Birthplace North Carolina

MOTHER
14. Maiden Name Viola Wilkins
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 26 1946 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1946, at 1:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1946, to Nov. 21 1946, and that I last saw him alive on Nov. 21 1946.

Immediate cause of death	Duration
Compound presentation.	
Prolapse of cord.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 11-21-46

YS 150

G15887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

Registered No. G15887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 W. Lanvale Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. DeBarry

3 (b) If veteran, name war	3 (d) Social Security Account No.
No	212-18-0052

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mamie DeBarry
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) 2/22/1864

8. AGE: Years	Months	Days	If less than one day
82	9	3	hr. min.

9. Birthplace New York, N.Y.
(Town, county, and state)
10. Usual Occupation Photo Ingraver
11. Industry or business Retired

FATHER
12. Name James DeBarry
13. Birthplace ?

MOTHER
14. Maiden Name ? Dohenne
15. Birthplace Ireland

16 (a) Informant Mrs. Mamie DeBarry
(b) Address 2901 W. Lanvale Street

17 (a) Burial (b) Date thereof 11/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Avenue

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1946, at 8:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29, 1929 to Nov. 25, 1946, and that I last saw him alive on Nov. 25, 1946.

Immediate cause of death Cardiac failure due to generalized arteriolosclerosis. — Duration: 1 week

Due to

Due to

Other Conditions Gastro duodeno ulcer.
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kurop M. D.
Address 3030 Edmondson Avenue Date signed 11/25/46

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Give the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G15888

BALTIMORE CITY HEALTH DEPARTMENT X/82

CERTIFICATE OF DEATH

Registered No. G15888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Write the causes of death clearly and legibly. Give correct age in especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Balto. Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Brookwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES GAREY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/46

8. AGE: Years	Months	Days	If less than one day
	3	19	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

FATHER
12. Name Joseph B. Garey Jr
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Cockrill
15. Birthplace Balto. Md.

16 (a) Informant Joseph B. Garey Jr.
(b) Address 5310 Brookwood Rd. Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Wm. Cody Inc
(b) Address 217 St. Paul St.

19 (a) (b) Registrar

NOV 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1946, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1946, to 11/24 1946 and that I last saw h. alive on 11/23 1946.

Immediate cause of death Cardio respiratory failure — Duration

Due to Atelectasis

Due to

Other Conditions Cerebral defect, spastic diplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Bronchopneumonia, atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp. Date signed 11/25/46

X

G15889 D BC# 53023 BALTIMORE CITY HEALTH DEPARTMENT G15889
G15889 CERTIFICATE OF DEATH 30F Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Aisquith St. Balto.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Torre

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 7, 1946
8. AGE: Years Months 3 Days 20 If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Vincent Torre
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Harriette Owings
15. Birthplace Baltimore, Md.

16 (a) Informant Mother of deceased
(b) Address same

17 (a) Burial (b) Date thereof 11/26/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) (Date rec'd by registrar) (b) Registrar

NOV 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1946, at 4:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1946 to Nov. 24 1946, and that I last saw h.e.r alive on Nov. 24 1946

	Duration
Immediate cause of death: Cardio-Resp. failure	
Due to: Pre-natal Diarrhea	4 weeks
Due to:	
Other Conditions: Congenital Syphilis (Include pregnancy within 3 months of death)	15 weeks

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Vincent Torre
Address Mercy Hospital Date signed 11/26/46

PLEASE WRITE PLAINLY, with unfading pencil. Do not use ink. Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

G15890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15890 Registered No.

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Fill in all blanks with the best information obtainable. Be sure to give the causes of death clearly and legibly. Please write the correct age in especially important. Physicians: please write the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saint Hosp
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E McLain

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 400-03-4211

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah E
6 (c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.) June 16 1908

8. AGE: Years 38 | Months 5 | Days 8 | If less than one day: hr. min.

9. Birthplace Louisville Ky (Town, county, and state)

10. Usual Occupation Euro Molder

11. Industry or business

FATHER
12. Name Willis D McLain
13. Birthplace Ky

MOTHER
14. Maiden Name Zeka Schafer
15. Birthplace Ky

16 (a) Informant Sarah McLain
(b) Address 335 S Conkling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (month) (day) (year)
(c) Cemetery or crematory Louisville
Location Louisville Ky

18 (a) Funeral director Wilson Gorsuch
(b) Address 1219 E Fort Ave

19 (a) NOV 26 1946 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/46 1946, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/ 1946, to 11/24 1946, and that I last saw h[illegible] alive on — 19—

Immediate cause of death: Pulmonary edema — Duration

Due to: Hypocardial insufficiency

Due to: Arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: None as above

of autopsy: Hosp. Pathologist. Autopsy Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Beismann

Address Univ Hospital Date signed 11/25/46 M. D.

For Dr J. R. Davis, by Howard [illegible], Pathologist

G15891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V171a

Registered No. G15891

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Fractured Squaw Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Presbury Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert W. Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-09-1205

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Leila
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16-1892

8. AGE: Years	Months	Days	If less than one day
54	1	7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Robert W. Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary
15. Birthplace Md

16 (a) Informant Mrs Leila Johnson
(b) Address 2815 Presbury St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 11/27/46

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 E Fort Ave

19 (a) NOV 29 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1946, at 7 p. m. 45

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull, Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/22/46 at 7:22 p. m. 1911
(b) Where did injury occur? Batts St East of Schroeder
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury? Fell - struck by Streetcar

23. Signature Howard J. [illegible] M.D.
Medical Examiner.
Date signed 11/25/46

VS 191

G15892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G15892

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 Lansing Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Lansing Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth R Bradford

3 (b) If veteran, name war: NC

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1904

8. AGE: Years 42 | Months 2 | Days 11 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: Timothy Shanahan
13. Birthplace: Maryland

MOTHER 14. Maiden Name: Margaret Roche
15. Birthplace: Maryland

16 (a) Informant: Morris M Bradford
(b) Address: 1719 Lansing Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville Md

18 (a) Funeral director: Wilson Gorsuch
(b) Address: 1217 E Fort

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Nov 23 1946.
and that I last saw him alive on Nov 23 46.

Immediate cause of death: pneumonia, Bronchial 3 Days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Casal Gordon M. D.
Address 2201 W. North Ave Date signed 11-25-46

X

G15893 BALTIMORE CITY HEALTH DEPARTMENT G15893

CERTIFICATE OF DEATH 1936

Registered No.

PLEASE WRITE PLAINLY, WITH ONE LETTER IN EACH SPACE. Use ink and write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Patapsco (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David C Crum

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Blanche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1894

8. AGE: Years	Months	Days	If less than one day
52	5	10	hr. min.

9. Birthplace Carroll Co (Town, county, and state)
10. Usual Occupation Hostler Md Railroad
11. Industry or business

FATHER
12. Name Joseph Crum
13. Birthplace Carroll Co

MOTHER
14. Maiden Name Kate Richter
15. Birthplace Carroll Co

16 (a) Informant Blanche S Crum
(b) Address Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28-46 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Carroll Co

18 (a) Funeral director H. Bankard, Son
(b) Address Westminster Md.

19 (a)

NOV 26 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946, at 6 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1946, to Nov. 25 1946 and that I last saw h[illegible] alive on Nov 25 1946.

Immediate cause of death	Duration
Myocardial Failure	1 hour
Due to Hypertensive C.V.H.D.	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M. D.
Address Hosp. Date signed 11/25/46

L

G15891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G15891 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2809 Parkwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Owings Gibbons

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John W Gibbons
6 (c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): July 30 1875
8. AGE: Years 71 | Months 9 | Days 26 | If less than one day: hr. min.
9. Birthplace: Balto Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Reisburgs Owings
13. Birthplace: Md

MOTHER
14. Maiden Name: Amelia King
15. Birthplace: Md

16 (a) Informant: James W Gibbons
(b) Address: 2809 Parkwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Nov (day) 27 (year) 1946
(c) Cemetery or crematory: Loudon Park
Location: Balto Md
18 (a) Funeral director: Rutherford & Co
(b) Address: 232 N Charles St
NOV 26 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1946, at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 19 46 to Nov 25 19 46 and that I last saw h alive on Nov 24 19 46.

Immediate cause of death: Cachexia — Duration

Due to: Infiltrating carcinoma of Rt breast

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: about 1 yr ago.
Major findings of operation: Carcinoma of Rt breast
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Franklin C. Leslie M. D.
Address: 1101 St Paul Date signed: 11/26/46

VS 150

Dr. Johnson

G15895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G15895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2103 Love Grove St
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Love Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addaide Penney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1902

8. AGE: Years	Months	Days	If less than one day
44	4	12	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name David Corbin
13. Birthplace VA

MOTHER
14. Maiden Name Frances Freeman
15. Birthplace VA

16 (a) Informant Charles Douglass
(b) Address 2103 Love Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) 11-26-1946 (b) Harrington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18, 1946 to Nov. 24 1946 and that I last saw him alive on Nov 23 1946.

Immediate cause of death

	Duration
Cerebral Hemmorhage	
Due to	
	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis E. Johnson M. D.
Address 2329 Guilford Ave Date signed Nov 26 1946.

PRINT WRITE PLAINLY, with unfading black ink. Do not abbreviate. Write the causes of death clearly and legibly. Give correct age in all cases where it is especially important. Physicians: please write this certificate carefully.

VS 150

G15896 — Dr. Adams — G15896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate. Write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 Latrobe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Latrobe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Mosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lemer Mosley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 1895

8. AGE: Years 51 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name William Mosley
13. Birthplace Va

MOTHER — 14. Maiden Name Fannie Brown
15. Birthplace Va

16 (a) Informant Lemer Mosley
(b) Address 1619 Latrobe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)

(c) Cemetery or crematory U S Dallo National
Location Baltimore National

18 (a) Funeral director Rayner Sanders
(b) Address 1413 E. Preston St

19 (a) [illegible] Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24-46 19__, to 11-23-1946, and that I last saw him alive on 11-23-1946.

Immediate cause of death: Intestinal Obstruction — Duration 9 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayne Adams, M. D.
Address 238 W Cary St Date signed

X

G15897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15897 X 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 Magnolia terrace
(c) Hospital or institution:
Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 Magnolia Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Himmelheber

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Frederick Himmelheber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1878

8. AGE: Years	Months	Days	If less than one day
68	4	21	hr. min.

9. Birthplace Baltimore. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Kramer
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Alt
15. Birthplace Germany

16 (a) Informant Eleanore Himmelheber Rubin
(b) Address 335 Magnolia Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 (month) (day) (year)
(c) Cemetery or crematory Mt. Lowen Cem. City
Location

18 (a) Funeral director Hillis Howard Howard
(b) Address 2005 Eutaw St

19 NOV 26 1946 (b) Signature of Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1946, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1946, to Nov 25 1946, and that I last saw h.e.r. alive on Nov. 25 1946.

Immediate cause of death Arteriosclerotic Gangrene — Duration 5 mos.

Due to Arteriosclerosis generalized

Due to

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation October 29, 1946

Major findings of operation: Arteriosclerotic gangrene of foot & gallbladder

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lois I. Jordan M. D.

Address Church Home Hospital Date signed Nov. 27 1946

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

VS 180

X

G15898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G15898 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 Eutaw St Ceci apts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Cohen Jackson Coale

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	widowed

6 (b) Name of husband or wife Isaac Coale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1872

8. AGE: Years	Months	Days	If less than one day
74	6	13	hr. min.

9. Birthplace New York City (town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eugene Jackson
13. Birthplace New York

MOTHER
14. Maiden Name Rebecca Cohen
15. Birthplace Balto Md

16 (a) Informant Mrs. May Jackson Long
(b) Address 6 Charlotte Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 1946 (month) (day) (year)
(c) Cemetery or crematory Cohen Private Cem.
Location 1200 Saratoga St Balto Md

18 (a) Funeral director Henry W. Eichna Sons Co
(b) Address McCulloh & Eutaw Sts

19 (a) (Date received by local registrar) (b) NOV 26 1946 Huntington Millinus, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Nov. 1946
and that I last saw h Ca alive on Nov. 15 1946

Immediate cause of death Carcinomatosis Duration 8 months
Due to 8 "
Due to over
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Morrison
Address 11 E. Chase St Date signed 11/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if unknown, state so. Insert exact date of birth and correct age in especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

C15899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. C15899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 No Bentalow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give County)
(d) Street No. 1525 No Bentalow St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 Months 1 Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Allen

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant Alan Cohen

(b) Address 3569 Greenlea Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-46 (month) (day) (year)

(c) Cemetery or crematory Loredale

Location Phila. Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Balto St

19 (a) (b)

NOV 26 1946 Huntington Williams, MD
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25- 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1945 to Nov. 25 1946 and that I last saw h alive on Nov. 25 1946.

Immediate cause of death Carcinoma of Bilateral Lung and Pleura. Metastatic

Duration

Due to Terminal Symptoms

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Kessler

Address 3314 W North Ave Date signed 11/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Insert correct age in years, months, days if under 1 year, hours if under 1 day. Write the cause of death clearly and legibly. Physicians: please write the age is especially important.

G15900 | BALTIMORE CITY HEALTH DEPARTMENT | G15900 Registered No.

CERTIFICATE OF DEATH 111B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address
(c) Hospital or Institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3017 Hudson St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Everett Crist

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-3761

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Rose Kreager
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24-1895

8. AGE: Years	Months	Days	If less than one day
51	2	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Roofer
11. Industry or business

FATHER
12. Name Harry Crist
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Updegraff
15. Birthplace Md.

16 (a) Informant Mable Schunk
(b) Address 2906 Hudson St.

17 (a) Burial (b) Date thereof Nov. 26-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2234 Jefferson St.

19 (a) Date received by registrar NOV 26 1946 (b) Huntington Williams, Md. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 1946, at 11:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Helfrich M.D.
Medical Examiner.
Date signed 23 Nov 46

G15901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1796

Registered No. G15901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) If hospital or institution: Maryland General Hospital Ward 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Winner Ave. (If rural, give location)
(e) Citizen of foreign country? Windsor (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine HOLDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 61 Months Sept. Days If less than one day hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Holden
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Wick
15. Birthplace Germany

16 (a) Informant Miss Myrtle Steyer
(b) Address Annapolis, Maryland

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Washington, D.C.

18 (a) Funeral director C. F. Lamprecht
(b) Address 4310 Liberty Heights Ave

19 (a) NOV 26 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1946 at 8:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Phenobarbital poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-25-46 1:45 P.M.
(b) Where did injury occur? 3006 Windsor Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Overdose Taking tablets

23. Signature George L. Mehrill M.D. Medical Examiner.
Date signed 11/26/46

VS 191

G15903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1128

Registered No. G3900

PRESS WHITE PRINT, WITH UNFADING INK. Do not write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter A (ZerKutis) Zakus

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-7368

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 th 1946, at 11 M

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6 1914

8. AGE: Years	Months	Days	If less than one day
32	2	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Ship fitter

11. Industry or business

FATHER 12. Name Pius Zakus
13. Birthplace Lith

MOTHER 14. Maiden Name Anna Junkutis
15. Birthplace Lith

16 (a) Informant Anna Polaski
(b) Address 804 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem
Location Beland Md

18 (a) Funeral director Joseph Kasinskas Inc.
(b) Address 60 E Washington St

19 (a) (Date rec'd by registrar) (b) Williamsport

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22/ 1946 to 11/25 1946, and that I last saw h. alive on 11/25/ 1946.

Immediate cause of death	Duration
Due to Toxic Hepatitis +	
Marked Jaundice	
Due to Chronic Glomerulonephritis	3 days
Due to	
Other Conditions Acute Gastritis	
Bil. Scarlet Fever February 28	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cause

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez M. D.
Address Maryland G. Hospital Date signed 11/26/46

VS NOV 26 1946

G15903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G15903

1-186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Delaware (b) County
(c) City or town Wilmington (If outside city or town limits, write RURAL and give town)
(d) Street No. 744 Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Meddleton, Delaware (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name Walter Williams

13. Birthplace Delaware

MOTHER 14. Maiden Name Edna Bard

15. Birthplace Delaware

16 (a) Informant Mrs. Corine Giles

(b) Address 113 Export St Wilmington Del

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director William F. Jackson

(b) Address 916 Penna. Ave

19 (a) NOV 26 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1946, at 11.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured 5th thoracic vertebra; crushing of thoracic spinal cord; spastic paralysis; chronic cystitis; chronic decubitus ulcers

Other Conditions Emaciation -

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-24-46 at 17/1 M.

(b) Where did injury occur? 754 Penna. Ave. Balto.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No

(d) Means of injury Jumped or fell from roof

23. Signature George B. Merrill M.D. Medical Examiner.

Date signed 11-25-46

VS 191

G15901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146

Registered No. G15901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 821 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rena Dorsey Barbour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fred. Barbour

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 11, 1909

8. AGE: Years 37 Months 8 Days 11 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER 12. Name Clarence Dorsey

13. Birthplace Md.

MOTHER 14. Maiden Name Georgiana Williams

15. Birthplace Md.

16 (a) Informant Mabel Cook

(b) Address 216 Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location

18 (a) Funeral director Mrs Jabie R. Williams

(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

Nov 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/46 19 A. at 9¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov / 1946 to 19 ; and that I last saw her alive on 19

Immediate cause of death: Cerebral Pneumonia — Duration 1 day

Due to Carcinoma Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter T. Cowan M. D.

Address 701 Edmondson Date signed

Write the causes of death clearly and legibly. Physicians: please write the correct age to especially important.

G15905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G15905 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount St.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Silver Spring (If outside city or town limits, write RURAL, and give town)
(d) Street No. 8722 Colesville Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wood

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7, 1887

8. AGE: Years 59 Months 4 Days 19 If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Dry cleaning business

FATHER
12. Name James Wood
13. Birthplace Scotland

MOTHER
14. Maiden Name Elsa Grant
15. Birthplace Scotland

16 (a) Informant George Wood
(b) Address 8722 Colesville Rd. Silver Spring, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30 1946 (month) (day) (year)
(c) Cemetery or crematory Rock Creek Cemetery
Location Silver Spring, Md.

18 (a) Funeral director Warren A. Humphreys
(b) Address Silver Spring, Md.

19 (a) Nov 1946 (b) registered Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 November 1946, at 3 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 November 1946, to 26 Nov. 1946, and that I last saw him alive on 26 Nov. 1946.

Immediate cause of death	Duration
Shock	
Due to Intestinal obstruction, acute	
Due to Operation - intestinal anastomosis	
Other Conditions Ca. of sigmoid colon	

(Include pregnancy within 3 months of death)

Date of operation 18 November 46

Major findings of operation: Carcinoma of sigmoid colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Ross M. D.
Address Church Home & Hospital Date signed 26 Nov 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15906 G15906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-9 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3829 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB Joseph WEITZEL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Grace Weitzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-1887

8. AGE: Years	Months	Days	If less than one day
59	1	15	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Huckster
11. Industry or business Self

FATHER
12. Name Thomas Weitzel
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret Lutz
15. Birthplace Balto., Md.

16 (a) Informant Grace Weitzel
(b) Address 3829 Hudson Street

17 (a) Burial (b) Date thereof 11-29-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Gorsuch Mill Rd.

18 (a) Funeral director Charles L. Seiler
(b) Address 3605 Taitt Ave.

19 (a) Huntington Williams M.D.
(Date received by registrar) Registrar
NOV 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1946, at 9 p.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 11/26/46

X

Correct age is especially important. Physicians: please write the address of Death's country and city.

G15907 BALTIMORE CITY HEALTH DEPARTMENT G15907

CERTIFICATE OF DEATH ✓47 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1490 N. Caroline St
(c) Hospital or institution: St Josephs Hospital 26-T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 E Lombard St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Herman G. Nehus (HERMAN G. NEHUS.)
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-7728

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife Cora Pearl Nehus
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JAN. 31, 1892.
8. AGE: Years 54 Months 9 Days 23 If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Cooper
11. Industry or business

PARENTS
12. Name JOHN NEHUS
13. Birthplace GERMANY.
14. Maiden Name ELIZABETH RODA.
15. Birthplace GERMANY

16 (a) Informant CORA PEARL NEHUS (WIDOW)
(b) Address 4215 E. LOMBARD ST.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location 7225 Eastern Ave.
18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.
19 (a) (Signature of registrar) (b) Date received NOV 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24-46 1946, at 10:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 11-24-46 1946, to 11-24-46 1946, and that I last saw him alive on 11-24-46 1946.

Immediate cause of death
Cardiac Failure
Bulbar Paralysis Edema
Due to Coronary Thrombosis
Due to Contusion - Ventricle

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Coronary Thrombosis.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify typical place)
(e) Means of injury
23. Signature [illegible]
Address St Joseph Hospital Date signed 11-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your name for identification.

G15908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 127a

G15908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Where any inquiry is not applicable, write the word "None." Do not abbreviate. Use full name of city or town. Do not use ditto marks. Do not write in figures where words are required, except age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. Warren Rd - York Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie I. Sunderland

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Lorin F. Sunderland 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 9 1871

8. AGE: Years	Months	Days	If less than one day
75	3	16	hr. min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name John Ford
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Bean
15. Birthplace Md

16 (a) Informant Henry F. Sunderland (Son)
(b) Address 3924 Leeds Ave., Baltimore, Md

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Nov. 27 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Co., Md.

18 (a) Funeral director C. Howard Evans
(b) Address 4005 Edmondson Ave., Balto. 29, Md.

(a) (b)
(Registrar) (Date received)

NOV 26 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1946, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1946 to Nov 25 1946, and that I last saw h. alive on Nov 25 1946.

Immediate cause of death	Duration
Acute Gastric Dilatation	
Cardiac Failure	
Due to Cholecystitis & Hydrops	
Arteriosclerotic C Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11/23/46
Major findings of operation: Cholecystitis & Hydrops
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature C. B. Marshall Jr. M. D.
Address Nursing Hosp. Date signed 11/26/46

X

G15909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1446

G15909
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1131 Gilmor St
(c) Hospital or institution: ~~Johns Hopkins Hospital~~ private patient
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Gilmor St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME London A. Whitted

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-16-8305

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of ~~husband~~ or wife Mary Whitted
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Dec 17 1904

8. AGE: Years	Months	Days	If less than one day
41 42	11	5	hr. min.

9. Birthplace Durham N. C.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name London Whitted
13. Birthplace Durham N. C.

MOTHER
14. Maiden Name Mary Sneed
15. Birthplace Durham N. C.

16 (a) Informant Mary Whitted
(b) Address 1131 Gilmor St

17 (a) Burial (b) Date thereof Nov. 27/46
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Cemetery Mt Calvary
Location Brooklyn

18 (a) Funeral director Dr Brooks Ruggold
(b) Address 1463 N. Carey St.

19 (a) Huntington Williams M.E.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946, to Nov 22 1946 and that I last saw ~~him~~ alive on Nov 22 1946.

Immediate cause of death Hodgkin's Disease — Duration 1 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Estelle Lee Frey M. D.
Address 1928 Parma Ave Date signed Nov 27 46

VS 150

X

G15910 G15910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correctly as possible. Every question is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 David Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Foust Foust

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/1906

8. AGE: Years	Months	Days	If less than one day hr.	min.
40	1	4		

9. Birthplace Granville Co., N.C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant William Waddell
(b) Address 834 Ninth St. N.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Ira Brooks
(b) 11-26-1946 1463 N. Carey St. Huntington Williams, M.D.
19 (Date rec'd by registrar) Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1946 at 12:22 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1946 to 11/23 1946, and that I last saw h[illegible] alive on 11/23 1946.

Immediate cause of death Uremia — Duration

Due to Arteriosclerotic nephritis — 8 days.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp. Date signed 11/26/46

X

Dr. A. Eisenberg
2025 E. North Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 61591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 E. Lanvale Stret
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 E. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Amelia Brückner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1859

8. AGE: Years	Months	Days	If less than one day
88 (87)	5	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John F. Brückner
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Graeser
15. Birthplace Germany

16 (a) Informant Mrs. Florence Wurst
(b) Address 412 E. Lanvale Street

17 (a) Bruial (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14

26 1946 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24th, 1946, at 2.30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 30 1945 to Nov 24 1946, and that I last saw her alive on Nov 24 1946.

Immediate cause of death: Cardiac Dilatation
Due to Gangrene Left Leg
Due to Arteriosclerosis right thigh
Due to
Other Conditions Cerebral Hemorrhage and Chronic Interstitial Nephritis
(Include pregnancy within 3 months of death)

Duration
20 yrs
8 yrs

Date of operation
Major findings of operation
of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Eisenberg
Address 2025 North Ave Date signed 11-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G15912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946

G15912 **Registered No.**

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Drury Lane DOA
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL, and give town.)
(d) Street No. 508 Drury Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland K. Hoke ~~Donald Hoke~~

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Mildred Lehnard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1891

8. AGE: Years	Months	Days	If less than one day
55	3	27	hr. min.

9. Birthplace Penna
(Town, county, and state)
10. Usual Occupation owner
11. Industry or business Keystone Electric Co.

FATHER
12. Name Jacob C Hoke
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Keilholtz
15. Birthplace Md.

16 (a) Informant Mrs Mildred Hoke
(b) Address 508 Drury Lane

17 (a) Burial (b) Date thereof Nov 22 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Henry H Weitzle
(b) Address 4101 Edmondson Ave

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by Registrar)
NOV 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1946 at 3:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. P. Lerkowski M.D.
Medical Examiner.
Date signed 11/25/46

correct age is especially important. Physicians: please

G15913 B-2633-62163 G15913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32d & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) (1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County Guilford
(c) City or town Greensboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby girl Barbary Meldon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-46

8. AGE: Years | Months | Days | If less than one day 1 hr. 30 min.

9. Birthplace Union Memorial Hosp.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John D. Weldon Jr.
13. Birthplace Georgia

MOTHER
14. Maiden Name Jean Barbary
15. Birthplace Nfld. Canada

16 (a) Informant Jean Barbary
(b) Address 604 N. Spring St. Greensboro N.C.

17 (a) — (b) Date thereof —
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory —
Location —

18 (a) Funeral director Disposed of by hospital
(b) Address —

NOV 26 1946 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946, at 2 40/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1946 to 11-14 1946, and that I last saw him alive on 11-14 1946.

Immediate cause of death Suffocation by (5 mon. fetus)
Due to Late abortion.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. Coates Sprunt M. D.
Address —
Date signed 11-20-46

X

G15911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1780

G15911 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Balto (If outside city limits write RURAL and give county)
(d) Street No. 647 W Lafayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) Y
If yes, name country

3 (a) FULL NAME Ruth Abel

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

20. DATE OF DEATH Nov 25 1946, at 4 45 M

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1892

8. AGE: Years	Months	Days	If less than one day
54	-	15	hr. min.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

9. Birthplace Hellam Township Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Carbon Monoxide gas

Other Conditions

(Include pregnancy within 3 months of death)

FATHER 12. Name Benjamin F. Abel
13. Birthplace

MOTHER 14. Maiden Name Helen Berg
15. Birthplace

16 (a) Informant Arlene O. Keller
(b) Address Glen Rock, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29 1946 (month) (day) (year)
(c) Cemetery or crematory Glen Rock, Pa
Location

18 (a) Funeral director W. C. Gilbert Glen Rock, Pa.
(b) Address

19 (a) Filed by (b) Huntingdon Williamsport Md

NOV 27 1946

VS 191

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov 25-1946 4 45 P M.
(b) Where did injury occur? 647 W Lafayette St
(c) Did injury occur in home, on farm, industrial place, in public place? Home (While at work)
(d) Means of injury Reduction of burned gases acting on base of cooking vessel.

23. Signature William F Kelbach M.D. (Medical Examiner)
Date signed Nov 26, 1946

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1319

G15915
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Kent
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Cannon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arlie A. Frisby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	Widow

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23-1883

8. AGE: Years	Months	Days	If less than one day
63	3	23	hr. min.

9. Birthplace Rock Hall, Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Daniel K. Johnson

13. Birthplace Md

14. Maiden Name Louise Bentley

15. Birthplace Md.

16 (a) Informant Norman Frisby - Son

(b) Address 447 N. 31st St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-46 (month) (day) (year)

(c) Cemetery or crematory Edesville
Location Kent Co. Md.

18 (a) Funeral director Samuel W. Sullivan Jr.

(b) Address 1011 N. Arlington Ave.

NOV 27 1946 Huntington Williams MD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item is important. Physicians: please write the exact age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1946, to 11/26 1946, and that I last saw h[illegible] alive on 11/26 1946

Immediate cause of death	Duration
Chr. Passive Congestion of Lungs	
Due to Cardio-Vascular Renal Disease	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 75 E. Pleasant Date signed 11-26-46

C15916 — AB-103516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. C15916

PLEASE WRITE PLAINLY, WITH UNFADING INK. ENTRIES must be made on both sides of certificate. Use only standard abbreviations. If unknown, write the word. Do not write in spaces marked "For Registrar's Use Only." Please write the correct age in especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos- 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14-1910

8. AGE: Years	Months	Days	If less than one day
36	6	8	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Easter Jones
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Sarah L. Brown & Son
(b) Address 104 W Montgomery St.

NOV 27 1946 Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Nov. 22- 1946, at 4.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1946 to 11-22- 1946, and that I last saw him alive on 11-22-46 19

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 3 yrs.

Due to

Due to

Other Conditions Diabetes Mellitus — 5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pulmonary Tuberculosis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. G. Burk M. D.
Address Balto City Hosp Date signed 11-25-46

X

G15917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47F

G15917

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 ✓ BARRINGTON RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 410 ✓ BARRINGTON RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ✓ JULIA KAUFMAN

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife HERBERT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 23 1909

8. AGE: Years	Months	Days	If less than one day
37	3	3	hr. min.

9. Birthplace BALTO. MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business

FATHER
12. Name ABRAHAM POLLACK
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ✓ BONNIE
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof (months) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location PHIL. RD & BOWLEYS LANE

18 (a) Funeral director VOLK LEWIS INC
(b) Address 1439 E. BALTO. ST

NOV 27 1946 (Date rec'd by Reg.) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1946, at 3 ✓ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Nov 26 1946 and that I last saw him alive on Nov 26 1946

Immediate cause of death
CARDIO-RESPIRATORY FAILURE — Duration

Due to CARCINOMA - ARISING FROM SUPERIOR MEDIASTINUM - TYPE
Due to UNDETERMINED - GENERALIZED DIFFUSE
Other Conditions CARCINOMATOSIS

(Include pregnancy within 3 months of death)
Date of operation AUG 28, 1946
Major findings of operations: CARCINOMA ARISING FROM SUP. MEDIASTINUM
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Appelfeld
Address 2511 Reisterstown Rd Date signed 11/27/46

X

G15918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write distinctly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 North Washington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frank KUST (Beatrice)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow.

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1896

8. AGE: Years	Months	Days	If less than one day
50	2	1	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Saleslady.

11. Industry or business

FATHER 12. Name Moses WOLFE

13. Birthplace Russia

MOTHER 14. Maiden Name Esther ?

15. Birthplace ? Russia

16 (a) Informant Frank Kuman

(b) Address 1703 Ruxton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)

(c) Cemetery or crematory Loredale

Location Philadelphia Rd & Hamilton ave

18 (a) Funeral director Jack Kaviz Inc.

(b) Address 1406 Gallo St

NOV 27 1946 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1946, at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21 1946 to 11-26 1946 and that I last saw h[illegible] alive on 11-26 1946.

Immediate cause of death	Duration
Coronary Thrombosis With Infarction.	?
Due to Arteriosclerotic	
Due to Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M. D.

Address Union Mem. Hosp. Date signed 11-26-46

15919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

C15919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 N. 40th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-E
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 N. 40th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David N. Wheeler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary Ellen Wheeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14-1868

8. AGE: Years 78 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (City or county, and state)

10. Usual Occupation Carpenter Foreman
11. Industry or business Retired 15 Years

FATHER 12. Name William N. Wheeler
13. Birthplace Maryland

MOTHER 14. Maiden Name Annie Rebecca Crabson
15. Birthplace Maryland

16 (a) Informant Mrs. Vernon Rosfeldt
(b) Address 1308 N. 40th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Dorsey Funeral Home
(b) Address 3231 Falls Road

NOV 27 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946, to Nov 25 1946, and that I last saw h[illegible] alive on Nov 24 1946.

Immediate cause of death: Congestive Heart Failure — Duration
Due to C.V.D. Myocarditis
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward R. Glasman, M.D.
Address 4037 Falls Rd. Date signed 6/26/46

VS 150

C15920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1932

Registered No. C15920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Booker Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Booker Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jefferson Warren

3 (b) If veteran, name war: —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6, 1897

8. AGE: Years	Months	Days	If less than one day
49	-	19	hr. min.

9. Birthplace Littleton N. Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Ship yard

FATHER
12. Name Henry Warren
13. Birthplace Littleton N. Carolina

MOTHER
14. Maiden Name Mary Alston
15. Birthplace Littleton N. Carolina

16 (a) Informant Roosevelt Warren
(b) Address 1733 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29/46 (month) (day) (year)
(c) Cemetery or crematory N. Calvary Cem
Location Balto. County Md

18 (a) Funeral director Mr. Robert E. Elliott Jr. Funeral
(b) Address 1129 N. Carlton St.

NOV 27 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1946 to Nov. 19 1946 and that I last saw him alive on Nov. 19 1946.

Immediate cause of death Acute Coronary Occlusion — Duration a few hours
Due to Myocarditis
Due to
Other Conditions Hypertension and Arthritis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. M. Lawrence
Address 1023 W. Lanvale St. Date signed 11/26/46 M. D.

VS 150

G15921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

Registered No. G15921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 E Gough St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 E. Gough St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS DAVIS HAMMETT

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Margaret Ahearn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11/[illegible]

8. AGE: Years	Months	Days	If less than one day
88	5	14	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Engineer (Retired)
11. Industry or business Penn. R.R.

FATHER
12. Name John R Hammett
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann B Zachary
15. Birthplace Maryland

16 (a) Informant Mildred Murphy
(b) Address 2202 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 29 46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Federick Rd.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St Balto 31

NOV 27 1946 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946, at 4:55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 6 1946 to Nov. 25 1946, and that I last saw h[illegible] alive on Nov 23 1946

Immediate cause of death: Senility — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Nowak M. D.
Address 408 S Patt. Pk Ave. Date signed 11/30/46

VS 150

X

G15922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15922 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Layard & Oakland
(c) Hospital or institution: West Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 3506 Howard Park Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry S. Crouse

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 204-22-0111

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	White	Widowed

6 (b) Name of husband or wife Jessie Webb Crouse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1883

8. AGE: Years	Months	Days	If less than one day
62	11	20	hr. min.

9. Birthplace Waynesboro, Pa. (Town, county, and state)
10. Usual Occupation Retired Civil Service
11. Industry or business U. S. Navy

FATHER
12. Name Jacob Crouse
13. Birthplace Pa.

MOTHER
14. Maiden Name Laura A. Smith
15. Birthplace Pa.

16 (a) Informant Mr. Jesse W. Crouse
(b) Address 29 W. Gay St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory
Location West Chester, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(c) NOV 27 1946 (Date rec'd by Registrar) (d) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 November 46 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Nov 19 46 to 26 Nov 19 46, and that I last saw h / he alive on 26 Nov 19 46.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Lobar Pneumonia Left	
Due to Coronary Arteriosclerosis & Arteriosclerosis of the C.N.S.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Leslie A. Shaw Jr. M. D.
Address West Baltimore Gen. Hospital Date signed 11/26

VS 150

G15923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G15923

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give locality)
(d) Street No. 647 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Polly Mann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace NAGSHEAD N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name WILLIAM BEASLEY

13. Birthplace NAGS-HEAD N.C.

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant CHARLIE JOHNSON

(b) Address NAGS-HEAD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 29. 1946 (month) (day) (year)

(c) Cemetery or crematory POLLY BURIAL GROUND

Location NAGS-HEAD N.C.

18 (a) Funeral director Ellsworth Armacost

(b) Address 3911 Liberty Heights Ave (Huntington Williams M.D.)

NOV 27 1946 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1946 at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon monoxide gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Nov 25 1946 at 9:45 P.M.

(b) Where did injury occur? 647 W Lexington St

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?

(d) Means of injury Reduction of burned gas d act- ing on base of cooking vessel.

23. Signature William J. Helfand M.D.
Medical Examiner.

Date signed Nov 26, 1946

VS 151

115024

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓61

G15924
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 72

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 Detroit Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANKLIN CHEERS THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Bertha Florence Thomas
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 9, 1874

8. AGE: Years	Months	Days	If less than one day
72	7	17	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Drone
11. Industry or business

FATHER
12. Name Elijah Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Cheers
15. Birthplace Maryland

16 (a) Informant Hospital record
(b) Address 33rd & Calvert Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2201 Gallows Rd Huntington Williams Md
(Date received) NOV 27 1946 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1946, at 302 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946, to Nov 26 1946, and that I last saw him alive on Nov 26 1946.

Immediate cause of death: Broncho-pneumonia, bilateral — Duration

Due to

Due to

Other Conditions: Diabetes mellitus, Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan R Chambers
Address Union Memorial Hospital Date signed Nov 27 46

107

C15925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. C15925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Charles & 32nd Sts.
(b) Street address Allston Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 32nd Sts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Dennis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Louise Craig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1870

8. AGE: Years	Months	Days	If less than one day
76	4	--	hr. min.

9. Birthplace Somerset County, Md. (Town, county, and state)
10. Usual Occupation attorney-at-law
11. Industry or business

FATHER
12. Name George R. Dennis
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Johnston
15. Birthplace Md.

16 (a) Informant Ellen Johnston Dennis
(b) Address 128 E. 61st St., N. Y. C-21

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

NOV 27 1946 (Date received) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1946, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1936 to Nov 25 1946 and that I last saw him alive on Nov 25 1946.

Immediate cause of death Pneumonia
Due to Hypostatic
Due to Arterio-Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H H Moody.
Address 1405 Park Ave. Date signed 11/26/46

VS 180

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G15926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G15926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 W. North Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Grace Schaut

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6. (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1883

8. AGE: Years	Months	Days	If less than one day
63	--	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation schoolteacher - retired

11. Industry or business

FATHER
12. Name William H. Schaut
13. Birthplace Fredericksburg, Va.

MOTHER
14. Maiden Name Annie Hughes Houston
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rona S. Reese
(b) Address 3312 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 27 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 November 1946, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 22 July 1946, to 27 Nov 1946, and that I last saw h[illegible] alive on 26 Nov 1946.

Immediate cause of death: Generalized Carcinomatosis — Duration 1 yr.

Due to Adeno carcinoma of Bladder — 7 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Scott M. D.
Address 8 Longwood Road Date signed 27 Nov 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

159127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

G159127 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correctly; it is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 N Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 815 N Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella Elizabeth B Sexton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife Charles Sexton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/1890

8. AGE: Years	Months	Days	If less than one day
56	8	23	hr. min.

9. Birthplace New York State
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Annie Brown
(b) Address 1410 N. Central ave

17 (a) Burial (b) Date thereof Nov. 27, 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Brantly ave

NOV 27 1946 Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, found that said deceased came to my death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cancer, abdominal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Stafford M.D.
Date signed Nov 24, 1946 Medical Examiner.

VS 191

C15928 — BALTIMORE CITY HEALTH DEPARTMENT — C15928 Registered No.

CERTIFICATE OF DEATH 1314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 44 S. Bond ST.
(c) Hospital or institution: 3-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) ←
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town.)
(d) Street No. 44 S. Bond ST. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Bowman.

3 (b) If veteran, name war /
3 (c) Social Security Account No. 217-09-015-0

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Married

6 (b) Name of husband or wife Maggie Bowman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1896

8. AGE: Years	Months	Days	If less than one day
50	7	28	hr. min.

9. Birthplace Lee County S. C. (town, county, and state)
10. Usual Occupation laborer.
11. Industry or business —

FATHER
12. Name Jones Bowman
13. Birthplace S. C.

MOTHER
14. Maiden Name Grace Ropbs.
15. Birthplace S. C.

16 (a) Informant Mrs Maggie Bowman
(b) Address 44 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/46 (month) (day) (year)
(c) Cemetery or crematory
Location South Carolina
18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Bryant St and
NOV 27 1946 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 27 1946, and that I last saw him alive on Nov 20 1946.

Immediate cause of death	Duration
(a) Acute myocardial failure	1 day
Due to Cardio renal disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. O. Burwell M. D.
Address 121 Augusta St Date signed 11-28-46

VS 150

G15939 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G15939

CERTIFICATE OF DEATH 937

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. No 8 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If so, name country

3 (a) FULL NAME Mathew Jarman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1906

8. AGE: Years	Months	Days	If less than one day
38	11	19	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Alfred Jarman
13. Birthplace North Carolina

MOTHER
14. Maiden Name Nancy Bailey
15. Birthplace North Carolina

16 (a) Informant Nellie Jarman
(b) Address 140 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

NOV 27 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

19. DATE OF DEATH Nov 25 1946, at 4:00 PM

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Williams T. Kelly M.D.
Date signed Nov 26, 1946 Medical Examiner.

VS 181

G15930 Dr. Sawyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G15930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5509 Elsrode Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5509 Elsrode Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Catherine Haydon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aprl. 3, 1856

8. AGE: Years 90 | Months 7 | Days 24 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James George
13. Birthplace Va.

MOTHER
14. Maiden Name ? Hammond
15. Birthplace Va.

16 (a) Informant: Mrs. Milton Ashburn
(b) Address 5509 Elsrode Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/ /46 (month) (day) (year)
(c) Cemetery or crematory Morratico Bapt. Cem.
Location Virginia

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

NOV 27 1946 (Date rec'd by Reg'r) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th, 1946 at 2 45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1946 to Nov 27 1946, and that I last saw h[illegible] alive on Nov. 26 1946.

Immediate cause of death: Cerebral Embolism — Duration: 4 days
Due to: Arteriosclerotic Heart Disease
Due to:
Other Conditions: Pulmonary Oedema. Hem. Hemiplegia (28)
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. Sawyer M. D.
Address 4808 Harford Rd Date signed 11/27/46

C15931

JL - 105454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

C15931

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Willie Belle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1888

8. AGE: Years 58 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Beth. Steel

FATHER
12. Name Joseph Henderson
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Yancy
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery to - Baltimore National Cem.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) 07 46 (Registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1946, at 3:25AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1946, to Nov. 24 1946, and that I last saw h. alive on Nov. 24 1946.

Immediate cause of death Bronchogenic Carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Doyle Walker M. D.
Address B.C.H. Date signed Nov 25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1214

G15932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 638 W Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days) 76-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 W. Lanvale (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Thompson
3 (b) If veteran, name war No
3 (c) Social Security Account No. None
4. Sex M. 5. Color or race W. 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Emma C. Thompson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1-16-1870
8. AGE: Years 76. Months 10 Days 4 If less than one day hr. min.
9. Birthplace [redacted] (Town, county, and state)
10. Usual Occupation R.R. Worker
11. Industry or business Retired
FATHER 12. Name William Thompson
13. Birthplace Scotland
MOTHER 14. Maiden Name Unknown
15. Birthplace Delaware
16 (a) Informant Emma C. Thompson
(b) Address 638 W Lanvale St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location
18 (a) Funeral director Charles W. Tschudy
(b) Address 703 N. Gilmor St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/46 1946, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15/46 19 to 11/19 19 46 and that I last saw h[illegible] alive on 11/19/46 19.

Immediate cause of death: Cardiac Arrest
Due to Hypostatic Pneumonia
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
"
"
"

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Tatum M.D.
Address 618 Edmondson Date signed 11-21-46

C15933 BALTIMORE CITY HEALTH DEPARTMENT C15933
Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
City or town Baltimore · 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 Overland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15-1893

8. AGE: Years	Months	Days	If less than one day
53	1	10	hr. min.

9. Birthplace Arthur - Illinois
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business B. & O. R.R.

FATHER
12. Name Abraham Miller
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Ohio.

16 (a) Informant Mr. Joseph L. O'Connell
(b) Address 4631 Atlantic Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-46 (month) (day) (year)
(c) Cemetery or crematory Mellinger Cem. Pa.
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

NOV 27 1946 (Date received by registrar) (b) Huntington Williamsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946, to Nov. 25 1946, and that I last saw h.. alive on Nov 25 1946.

Immediate cause of death: Massive Pulmonary Embolism — Duration: 2 days

Due to Coronary Thrombosis — Duration: 2 wks.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Marmon M. D.
Address Univ. Hosp. Date signed 11/26/46

X

G15931 BALTIMORE CITY HEALTH DEPARTMENT G15931
CERTIFICATE OF DEATH 1937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6077 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-5
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs 8 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6077 Harford Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley Francis Hupfeld

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Ethel Marie Fahey
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 9-27-1892

8. AGE: Years	Months	Days	If less than one day
54	2	0	hr. min.

9. Birthplace Baltimore md (Town, county and state)
10. Usual Occupation Furniture buyer
11. Industry or business Department store

FATHER
12. Name George Hupfeld
13. Birthplace Baltimore, md

MOTHER
14. Maiden Name Anna Parr
15. Birthplace Baltimore md

16 (a) Informant: Mrs Ethel Hupfeld
(b) Address 6077 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Longrod & Kuck
(b) Address 5305 Harford Rd.

NOV 27 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1946, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from September 1946, to Nov. 27 1946, and that I last saw him alive on Sept. 26 1946.

Immediate cause of death Heart failure — Duration

Due to Hypertensive cardio-vascular disease — One year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Monday 1946

Major findings of operation: Satisfactory

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ronald Jandorf M. D.
Address 6077 Harford Rd Date signed 11-29-46

X

G15935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G15935 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 N. Chapel Gate Lane
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N. Chapel Gate Lane. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Charles S. Lewis

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No. 220-01-6494

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Abbie B. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1876

8. AGE: Years 70 Months 4 Days 9 If less than one day — hr. — min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Detective
11. Industry or business Hochschild-Kohn Co.

FATHER
12. Name E. Stephen Lewis
13. Birthplace Maryland

MOTHER
14. Maiden Name Cidney V. Welsh
15. Birthplace Maryland

16 (a) Informant Mrs. Abbie B. Lewis
(b) Address 611 N. Chapel Gate Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) Date received 1946 (b) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Nov. 24 1946, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1946, to Nov 24 1946, and that I last saw him alive on Nov. 24 1946.

Immediate cause of death: Coronary Throm Dosis — Duration 40 days.
Due to Arteriosclerosis — ?
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O Walter Spurrier MD
Address 3603 Edmondson Ave Date signed 11/26/46

VS 150

X

G15336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G15336 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ERASE WRITE PLAINLY WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5101 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES M. FORSYTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Willian Howard Forsyth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1868

8. AGE: Years	Months	Days	If less than one day
78	8	3	hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Clerk - retired
11. Industry or business Lycett

FATHER
12. Name Alexander Barnett
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name ? Chase
15 Birthplace Pa.

16 (a) Informant Mr. D. B. Young
(b) Address 5101 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11-27-1946 (Date) (b) Huntington Nelligan, M.D. (Signature of registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1946 to 11-27 1946 and that I last saw h alive on 11-26 1946.

Immediate cause of death	Duration
Myocardial Failure	Days
Due to Arteriosclerotic Cardio Vasc Disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos F Talbot M. D.
Address 4509 Liberty Heights Date signed 11-27

G15937 BALTIMORE CITY HEALTH DEPARTMENT G15937
CERTIFICATE OF DEATH 1946
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Eutaw Place. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sarah Jane Keith.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George D. Keith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1865

8. AGE: Years	Months	Days	If less than one day hr.	min.
81	1	23		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Edward Brown
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Bevan
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Margaret E. Brown
(b) Address 304 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Local Registrar) (b) Hester Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26-46 1946, at 9.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1946, to 11-26 1946, and that I last saw him alive on 11-26 1946.

Immediate cause of death: Cardiac decompensation
Due to Arteriosclerotic Heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration
3 years.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman R. Freeman Jr. M. D.
Address Union Mem. Hosp. Date signed 11-26-46

G15938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G15938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Berwyn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Berwyn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAROLINE W. MARTIN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	Female	White	Widow

6 (b) Name of husband or wife David B. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1850

8. AGE: Years	Months	Days	If less than one day
96	3	7	hr. min.

9. Birthplace Dayton, Ohio (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John V. Nauerth
13. Birthplace Unknown

MOTHER
14. Maiden Name Smith
15. Birthplace Unknown

16 (a) Informant Mrs J. Frank Ryley
(b) Address 3502 Berwyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased ~~last seen~~ 19 days 19
and that I last saw h[e] alive on 11/26 1946.

Immediate cause of death Cerebral embolism
Due to Senility

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Rocapell M. D.
Address 3902 Woodland Blvd Date signed 11/29/46

Void 150

G15939 — BALTIMORE CITY HEALTH DEPARTMENT — G15939 Registered No.

CERTIFICATE OF DEATH 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 S. Monroe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HANSE H. BRADLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-9399

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1884

8. AGE: Years 62 | Months 5-4 | Days 12 | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Smith Building

FATHER
12. Name George W. Bradley
13. Birthplace Philadelphia

MOTHER
14. Maiden Name Mary J. Smith
15. Birthplace Pennsylvania

16 (a) Informant Mary Bradley
(b) Address 634 S. monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Wm Cooke Inc.
(b) Address 1217 St Paul Street

Nov 27 1946 (Date rec'd by Registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1946 at 1 p. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured neck
Fractured ribs
Bilateral hemothorax
Pulmonary edema

Other Conditions Bicuspid aortic valve with chronic bacterial endocarditis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/25/46 1 P. 4/1 M.
(b) Where did injury occur? 115 S. Hanover St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Fell from 6th floor hole

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 11/27/46

VS 191

CAUSE WHETHER FROM DISEASE OR VIOLENCE. Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G15910 G15910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
Union Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED: Allegany
(a) State Md (b) County Frederick
(c) City or town Cumberland.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 Frederick St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lew E. Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Grace Davis.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Wales
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Hospital

12. Name	James Davis
13. Birthplace	Wales
14. Maiden Name	Martha Frances
15. Birthplace	Wales

16 (a) Informant Mrs Gracie Davis
(b) Address 128 Frederick St Cumberland
17 (a) removal (b) Date thereof Nov 27 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Castle
Location New Castle, Pennsylvania
18 (a) Funeral director Wm Cook Jnr
(b) Address 1212 St Paul St East
19 (a) [illegible] Hamilton Williamson, M.D. Registrar
(Signature of registrar)

27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Nov 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1946. to Nov 26 1946.
and that I last saw him alive on 11-26 1946.
Immediate cause of death Hemorrhage

Duration

Due to probably due to erosion of blood vessel in lung abscess
Due to
Other Conditions Probable Bronchogenic Carcinoma
(Include pregnancy within 3 months of death)
Date of operation 10-9-46
Major findings of operation: Lung Abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature G K Briggs M.D.
Address Union Hosp Date signed 11-27-46

X

G15911 — BALTIMORE CITY HEALTH DEPARTMENT X — G15911

CERTIFICATE OF DEATH √39

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 6213 N. Howard St. (If rural, give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Roseling, Rudolph C.

3 (b) If veteran, name war: ?

3 (c) Social Security Account No.: ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Paula Wendert Roseling

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): May 11, 1892

8. AGE: Years 54 | Months 6 | Days 15 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Master

11. Industry or business: Seafarer

FATHER
12. Name: Charles Roseling
13. Birthplace: Germany

MOTHER
14. Maiden Name: Frederica Grone
15. Birthplace: Germany

16 (a) Informant: Mazine Hoe Md
(b) Address: Baltimore

17 (a) Burial, cremation, or removal: (b) Date thereof: 11-29-46 (month) (day) (year)
(c) Cemetery or crematory: Philadelphia
Location: Philadelphia Pa

18 (a) Funeral director: Kelly & Son Inc
(b) Address: 1317 N Front St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1946, at 2:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946, to Nov. 26 1946, and that I last saw him alive on Nov. 26 1946.

Immediate cause of death: Arteriosclerotic heart disease
Infarction of myocardium due to ~~Duration~~ arteriosclerotic coronary thrombosis — Duration: UNKNOWN

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 11/27/46

VS 180

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15912 — 112 — Registered No. 10512

Write the causes of death clearly and legibly. Physician: please write in ink. Do not use abbreviations. Correct age is especially important. Please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK L. BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b). Name of husband or wife: Margaret Shultz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1900 or 1910

8. AGE: Years 36 ~~42~~ ~~35~~ | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual Occupation Employed Armman Hammer
11. Industry or business Preston Ring

FATHER
12. Name J Lee Brown
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Rose Rowe
15. Birthplace Carroll Co.

16 (a) Informant Margaret S. Brown
(b) Address Monumtown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30 46 (month) (day) (year)
(c) Cemetery or crematory Monumtown
Location Carroll Co

18 (a) Funeral director H. Bankard, Son
(b) Address Westminster md.

19 (a) (b)
(Date received by registrar) (Registrar)
NOV 27 1946 Hampton Williams, Jr.
VS 1st 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 5.50 A.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute congestive cardiac failure

Asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas L. Mulfinger M.D.
Medical Examiner.
Date signed 11-27-46

G15913 Birth Certificate B-62850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G15913 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John St. & Lafayette Ave.
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mins

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Tunbridge Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mc Cleary

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	(illegible)

6 (b) Name of husband or wife (illegible)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24th 1946

8. AGE: Years	Months	Days	If less than one day
			0 hr. 5 min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation (illegible) Farm
11. Industry or business None

FATHER
12. Name Brad Baxter Mc Cleary
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Harriet Jemmes
15. Birthplace Baltimore Md.

16 (a) Informant Brad B. Mc Cleary.
(b) Address 320 Tunbridge Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cremated at Location Woman's Hospital

18 (a) Funeral director
(b) Address

NOV 27 1946 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24th 1946, at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1946 to Nov. 24th 1946, and that I last saw him alive on Nov 24th 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity (2 lbs 4 oz)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy None None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature (illegible) M. D.
Address Woman's Hospital Date signed 11-27-46

G15211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G15211 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 Sheffield Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name county)
(d) Street No. 1520 Sheffield Rd. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence A. Langston.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Georgia E Langston

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 1 1867

8. AGE: Years 79 Months 6 Days 26 If less than one day: hr. min.

9. Birthplace Hancock Md (Town, county and state)

10. Usual Occupation Minister, Retired

11. Industry or business

FATHER
12. Name John G. Langston.
13. Birthplace

MOTHER
14. Maiden Name Sarah Rudolph.
15. Birthplace ?

16 (a) Informant Georgia E. Langston
(b) Address 1520 Sheffield Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 1946 (month) (day) (year)
(c) Cemetery or crematory Parish
Location Linton Va

18 (a) Funeral director C. Langworth Dawson
(b) Address 3615 17 Montana Ave.

NOV 28 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Nov 1946, to 27 Nov 1946, and that I last saw him alive on 27 Nov 1946.

Immediate cause of death: Heart failure — Duration: 3 mo

Due to Arteriosclerotic Cardiovascular Disease — 3 yrs

Due to Senility

Other Conditions Chronic glomerulonephritis — 5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy M. Winner

Address 2000 Highland Ave Date signed 28 Nov 46

X

C15915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1164c

Registered No. C15915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707- W. 37th Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD L. STERNER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1931

8. AGE: Years	Months	Days	If less than one day
15	7	4	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation School - Boy
11. Industry or business

FATHER
12. Name Alfred L. Sterner, Sr.
13. Birthplace Md

MOTHER
14. Maiden Name Mary Delores McMahon
15. Birthplace Md.

16 (a) Informant Alfred L. Sterner, Sr.
(b) Address 707 W. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 30/46 (month), (day), (year)
(c) Cemetery or ~~crematory~~ St. Mary's
Location Hampden

18 (a) Funeral director Chenowith & Brooks
(b) ~~Undertaker~~ Huntington Williams, M.D.
NOV 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1946, at 5.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gunshot wound of head, involving Brain
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-26-46 at 5:00 P.M.
(b) Where did injury occur) 707 W. 37th St.
(c) Did injury occur at home, on farm, industrial place, in public place) Home Whilewat work? No
(d) Means of injury Shot self with rifle.

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 11-27-46

VS 191

PLEASE WRITE PLAINLY WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15916 BC# B4239 **BALTIMORE CITY HEALTH DEPARTMENT** G15916
CERTIFICATE OF DEATH 107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 Boyd Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Boyd Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLE WILSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 27, 1943

8. AGE: Years	Months	Days	If less than one day
1	9	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name William H. Wilson
13. Birthplace Martinsburg, W. Va.
MOTHER 14. Maiden Name Nora Hatter
15. Birthplace West Va.
16 (a) Informant Mrs. William H. Wilson
(b) Address 1020 Boyd St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46
(c) Cemetery or crematory Mountain View Cem
Location Follansbee, W. Va.
18 (a) Funeral director John J. Gorman & Son
(b) Address 901-03 Fallsway
19 (a) (Day of death) (b) Huntington Williams, M.D. Registrar
NOV 28 1946

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov. 27 1946, at 12.45 P M

21. I certify that I took charge of the remains described above, held an _____ (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions Upper Respiratory Infection
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malecsi M.D.
Medical Examiner.
Date signed 11/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate for every death. Write the causes of death clearly and legibly. Physicians: please write the correct age in every case. Accuracy is especially important.

G15917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15917 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Lyndhurst
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Lyndhurst. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Rutherford Burton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Helen Lee Divinega 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 - 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	9			

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired Insurance

11. Industry or business Monumental Life

FATHER — 12. Name Robert Burton
13. Birthplace Md

MOTHER — 14. Maiden Name Annie Eacame
15. Birthplace Md

16 (a) Informant Mrs R B Burton
(b) Address 423 Lyndhurst

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Rd.

18 (a) Funeral director J. Fenton Lane
(b) Address 1312 E Eager St.

19 (a) (Date received by registrar) (b) Registrar

NOV 28 1946

Huntington Williams, M.D.

OS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1946 at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1946 to 11-26 1946 and that I last saw h[illegible] alive on 11-26 1946

Immediate cause of death Cerebral hemorrhage and myocardial failure — Duration 2 days

Due to Arteriosclerosis and myocarditis — Duration one year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature [illegible]
Address 8921 Edmondson Ave M. D.
Date signed 11-27 1946

[illegible] MD

G15918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G15918 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hopkins apts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 31st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Boyle

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Helen L Boyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/1877

8. AGE: Years	Months	Days	If less than one day
69	2	23	hr. min.

9. Birthplace Lutherstown Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry F Boyle
13. Birthplace Md

MOTHER
14. Maiden Name Cordelia Downey
15. Birthplace Ohio

16 (a) Informant Mrs H L Boyle
(b) Address Chas & 31st

17 (a) Interment (b) Date thereof 11/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Druid Hill Ave

18 (a) Funeral director J J Doherty & Sons
(b) Address 32 S Light St

NOV 28 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1946, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Nov 26 1946.
and that I last saw h alive on Nov 16 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions Contributing but not related to Renal Disease. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Angela J Geraghty M.D.
Address 3047 Auchentoroly Terr Date signed 11/29/46

VS 150

X

C15919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C15919
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Villa Nova Road.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HILDA FISHER MERFELD.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Bernard Merfeld, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1892.

8. AGE: Years	Months	Days	If less than one day
54	8	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel L. Fisher,
13. Birthplace Russia.

MOTHER
14. Maiden Name Martha Helstein,
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Bernard Merfeld,
(b) Address Villa Nova Rd. Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/46, (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Harris Sonnenstein & Son
(b) Address 1902 Eutaw Place.

19 (a) NOV 28 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1946, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 19 1946, to Nov 26 1946, and that I last saw h[illegible] alive on Nov 26 1946.

Immediate cause of death
2 Ocular Tumor, Left Neuroepithelioma eyes enucleated
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy See above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Rothschild M.D., for Harry Mc Cormick M.D.
Address [illegible] Hospital Date signed 11/26/46

G15950 BALTIMORE CITY HEALTH DEPARTMENT G15950
CERTIFICATE OF DEATH 95c Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 Brooks Lane.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Brooks Lane. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS GOODMAN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Ernie M.Goodman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1859.

8. AGE: Years 87 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Austria. (Town, county, and state)
10. Usual Occupation Retired Distiller.
11. Industry or business

FATHER
12. Name Aaron Goodman,
13. Birthplace Austria.

MOTHER
14. Maiden Name Unknown,
15. Birthplace Austria.

16 (a) Informant Mrs. Louis Diener (Daughter)
(b) Address 934 Brooks Lane.

17 (a) Removal & Burial (Burial, cremation, or removal) date thereof 11/28/46. (month) (day) (year)
(c) Cemetery or crematory Clifton
Location Cincinnati, Ohio.

18 (a) Funeral director David Sonneborn Chapel
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th. 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to Nov. 27 1946, and that I last saw him alive on 11-21 1946.

Immediate cause of death: Cardiac insuff
Due to: Senility
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Bernard Cohen M. D.
Address Marlborough Apts. Date signed

VS 150

X 11-27-46

G15951 BALTIMORE CITY HEALTH DEPARTMENT G15951

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15th Division St
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 09 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 W. Lanvale
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander T. Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-2966

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: I. Viola Freeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 13, 1886

8. AGE: Years 60 | Months 0 | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Clothing Packer

11. Industry or business

BROTHER / FATHER
12. Name: John Freeman
13. Birthplace: Md

MOTHER
14. Maiden Name: Mamie Peters
15. Birthplace: Md

16 (a) Informant: I. Viola Freeman
(b) Address: 1324 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 29-46 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Cem
Location

18 (a) Funeral director: James A. Stevens
(b) Address: 142 Wabash St

19 (a) [illegible] for Williams, Md. Registrar

NOV 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26th 1946, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to Nov 26 1946 and that I last saw h. alive on Nov 26 1946

Immediate cause of death: Cerebral Hemorrhage

Due to: Illness

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: Died

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Charles O. Wardlaw

Address: 5 E. Preston St Date signed: 11-27-46

95 180

G15953 — BALTIMORE CITY HEALTH DEPARTMENT — G15953 Registered No.

CERTIFICATE OF DEATH 43a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 – 5th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 3607 – 5th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julian Bryant

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Hester P. Bryant
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan 7 – 1879 1879

8. AGE: Years 67 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Reedsville, Pa. (Town, county, and state)
10. Usual Occupation Retiring
11. Industry or business

FATHER
12. Name Melvin Bryant
13. Birthplace Reedsville, Pa.

MOTHER
14. Maiden Name Elin Elmore
15. Birthplace Reedsville, Pa.

16 (a) Informant Hester P Bryant
(b) Address 3607 – 5th St Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Towell
(b) Address 2427 Edmondson Ave

19 (a) NOV 28 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26th 1946, at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Nov 26 – 1946, and that I last saw him alive on Nov 26 1946.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Ave Date signed Nov 27 '46

G15953 — BALTIMORE CITY HEALTH DEPARTMENT — G15953 Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jacob Wise

13. Birthplace ?

MOTHER 14. Maiden Name Mary ?

15. Birthplace ?

16 (a) Informant Geo. L. Fahrbecker

(b) Address 3507 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29/46 (month) (day) (year)

(c) Cemetery or crematory Ger. Cath. Location Old Frederick Rd.

18 (a) Funeral director John A. McCann

(b) Address 3200 E. Balto. St.

19 (a) (b) Huntington Williams Md.

NOV 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1946, at 1:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1946 to 11-27 1946 and that I last saw her alive on 11-27 1946.

Immediate cause of death	Duration
Cardio resp failure	
Due to Cerebral hemorrhage	
Due to Hypertension	
Other Conditions Art. S. Heart disease. Hypertension Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.

Address Calvert & Saratoga Date signed 11-27-46

X

G15951 G15951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE STS.
(c) Hospital or institution:
UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 1 DAY

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County CARROLL
(c) City or town NEW WINDSOR
(If outside city or town limits, write RURAL and give town)
(d) Street No. NONE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FOSTER J. DYER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-1197

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife LYDIA SWEET
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7-1887

8. AGE: Years	Months	Days	If less than one day
59	5	20	hr. min.

9. Birthplace NEW YORK STATE (Town, county, and state)
10. Usual Occupation INNKEEPER AND OPERATOR
11. Industry or business

FATHER 12. Name WILLIAM FOSTER
13. Birthplace NEW YORK

MOTHER 14. Maiden Name MARY HOWARD
15. Birthplace NEW YORK

16 (a) Informant ROBERT FOSTER
(b) Address NEW WINDSOR MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 30-46 (month) (day) (year)
(c) Cemetery or crematory Wesleyan Cemetery
Location New Windsor Md. R.F.D.

18 (a) Funeral director J. W. Bartlett & Sons
(b) Union Bridge & New Windsor Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-46 19 at 7.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1946 to 11-27 1946, and that I last saw him alive on 11-27 1946.

Immediate cause of death CEREBRAL ANEMIA AND ACIDOSIS — Duration

Due to MASSIVE GASTRO-INTESTINAL HEMORRHAGE

Due to ESOPHAGEAL VARICES

Other Conditions CIRRHOSIS OF LIVER

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Workman M. D.
Address University Hosp. Date signed 11-27-46

X

G15055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1794 X

Registered No. G15055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Riveria Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maxine SEARLS (Georgia Anderslung?)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1929

8. AGE: Years 17 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Leo Searls
13. Birthplace Unknown

MOTHER
14. Maiden Name Georgia Williams
15. Birthplace Ohio

16 (a) Informant Mrs Georgia Searls
(b) Address Bay Drive Meadow Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/46 (month) (day) (year)
(c) Cemetery or crematory Riverview Cem.
Location Athens Ohio

18 (a) Funeral director John F Kenny Inc
(b) Address 745 Light St

19 (a) NOV 29 1946 (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 9.10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Oxalic acid Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-27-46 at 5:00 P.M.
(b) Where did injury occur? Riveria Beach, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of poisons Thought to be water

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 11-23-46

Interview Williams, M.D.

X

G15956 BCH G 62513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G15956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument
(c) Hospital or institution: SINAI
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto.
(c) City or town BALTIMORE - 21 (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Edgewater Apts. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL HERION

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1946

8. AGE: Years	Months	Days	If less than one day
			9 hrs min.

9. Birthplace Balto., MD (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name CONRAD M. HERION

13. Birthplace BALTO., MD

MOTHER 14. Maiden Name ROSETTA HESTERMAN

15. Birthplace

16 (a) Informant MRS. ROSETTA HERION

(b) Address 433 Edgewater Apts

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical Schoo NOV 27 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 29 1946 (Delivered to Registrar) Hunter Jr. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1946 at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946, to Nov 2 1946, and that I last saw h alive on Nov 2 1946

Immediate cause of death: Respiratory Failure — Duration 9 hrs.

Due to Prematurity — 9 hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —/A

Major findings of operation: —/A

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —/A.

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. M. Lewis M. D.

Address Sinai Hosp. Date signed Nov 2

VS 150

G15357 G15357

BCH

BALTIMORE CITY HEALTH DEPARTMENT

G62560 CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Binai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2da 3hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shores

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4 1946

8. AGE: Years | Months X | Days 2 + 3 hrs. | If less than one day ____ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alvin P. Shores
13. Birthplace Clarke, Md.

MOTHER
14. Maiden Name Amelia Dreyer
15. Birthplace Balto., Md.

16 (a) Informant Amelia Shores
(b) Address 603 N. Port St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Lo[illegible] Hopkins Medical Schoo NOV 27 1946
Commissioner of Health

18 (a) Funeral director

(b) Address

NOV 29 1946 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1946 at 6:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1946, to Nov 6 1946 and that I last saw h[illegible] alive on Nov 6 1946

Immediate cause of death: Respiratory failure — Duration 2 hrs.

Due to Prematurity — 27 hrs.

Due to

Other Conditions DEFORMITY OF CHEST WALL — 27 hrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged ultimately.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos Evans M. D.
Address Bonaw Hosp. Date signed Nov 3

VS 150

G15958 BC# G15958

BALTIMORE CITY HEALTH DEPARTMENT

G59383 CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: SINAI
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 7 DAYS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE-18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 E. LORRAINE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Boak "A"
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1946 (5:58 PM)

8. AGE: Years	Months	Days	If less than one day
		7h	hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name COURTLAND BOAK
13. Birthplace PITT., PA.

MOTHER
14. Maiden Name Helen Gershowitz
15. Birthplace BALTO., MD

16 (a) Informant MRS. Helen BOAK
(b) Address 308 E. LORRAINE AVE

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 27 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 29 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1946 at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1946 to Oct 23 1946 and that I last saw him alive on Oct 23 1946

Immediate cause of death Respiratory failure. — Duration

Due to Prematurity

Due to

Other Conditions Icterus neonatorum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sydney Green M. D.
Address Sinai Hospital Date signed 11/26/46

VS 150

G15959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15959 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 S. Augusta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 S. Augusta Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EFFIE AMELIA BURROWS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Denny W. Burrows
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1874

8. AGE: Years	Months	Days	If less than one day
72	10	9	hr. min.

9. Birthplace Philadelphia, (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William A. Granger
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Mary E. Parsley
15 Birthplace Balto., Md.

16 (a) Informant Mr. Denny W. Burrows
(b) Address 317 S. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Olivet Cemetery
Location St. Michaels, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

NOV 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1946 at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9-44 19..., to 11-26 1946, and that I last saw h[illegible] alive on 11-24-46 19...

Immediate cause of death: Arteriosclerosis/Last disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Hunter M.D.
Address 203 Edmondson Date signed 11-27-46

X

G15960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15960 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 St Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 St Paul St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charlotte Baldwin Cain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife J Henry Cain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16 1867

8. AGE: Years	Months	Days	If less than one day
79	2	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Silas Baldwin
13. Birthplace Md

MOTHER
14. Maiden Name Susan Ashton
15. Birthplace Md

16 (a) Informant Mrs Wm A White
(b) Address 3005 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29/46 (month) (day) (year)
(c) Cemetery or crematory Christ Church
Location Rock Spring

18 (a) Funeral director Degner & Foster
(b) Address Belair Md

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27th 1946, at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to Nov 27th 1946 and that I last saw her alive on November 26th 1946.

Immediate cause of death: Cerebral hemorrhage.
Hypostatic pneumonia.
Due to Cardio Vascular disease.
Due to Arteriosclerosis.
Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Baker M. D.
Address 3005 St Paul St Date signed 11-27-46

correct age is especially important. Physicians: please write

G15961 BC# G 56294 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH √107 Registered No. G15961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 6103 Fair Oaks Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Roy Smoot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1946

8. AGE: Years Months 2 Days 28 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Carl Lee Smoot
13. Birthplace Virginia

MOTHER 14. Maiden Name Doris Williams
15. Birthplace Virginia

16 (a) Informant Mrs. Doris Smoot
(b) Address 6103 Fair Oaks Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 29-46 (month) (day) (year)
(c) Cemetery or crematory SAUMSVILLE Cem.
Location WOODSTOCK V.A.

18 (a) Funeral director John O Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) NOV 29 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1946, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1946 to Nov. 28 1946, and that I last saw him alive on Nov. 28, 1946.

Immediate cause of death: Cardio - Resp. failure — Duration
Due to: Bronchio-pneumonia, bi-lateral
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas H Lennon M. D.
Address Mercy Hospital Date signed 11/29/46

X

G153682 G153682

BCH 963598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen'l Hosp 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 Linden St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Stambaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 10 Hrs 1946

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Leo Stambaugh
13. Birthplace Portage, Pa.

MOTHER
14. Maiden Name Janet Maude Alford
15. Birthplace Portage, Pa.

16 (a) Informant Mother
(b) Address Same as above.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 29 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1946, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1946 to 11/23 1946, and that I last saw him alive on 11/23 1946.

Immediate cause of death: Respiratory failure — Duration

Due to Premature 13 days

Due to 22 hrs grand Bunjoi

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cohen
Address South Balto Gen'l Hosp Date signed 11/24/46 M. D.

VS 150

G15363 DC# 262114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G15363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reynce Reed Dukeland St
(c) Hospital or institution: W. Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Linden Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Corden - D

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1946

8. AGE: Years	Months	Days	If less than one day
			18 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Earl David Corden

FATHER 13. Birthplace Christiansburg, Va.

MOTHER 14. Maiden Name Beulah Mae Reed

MOTHER 15. Birthplace Cambria, Va.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School NOV 27 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 29 1946 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-46 19 at 3:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-17 1946, to 11-18- 1946 and that I last saw her alive on 11-18 1946.

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Atelectasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. D. Trepton M. D.

Address Date signed

VS 150

BCH

962113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 615964

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reyner Ave & Pulaski St.
(c) Hospital or institution: W. Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Linden Ave #D
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Carden - A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1946

8. AGE: Years	Months	Days	If less than one day
		F	12 hr. 47 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl David Carden
13. Birthplace Christiansburg, Va.

MOTHER
14. Maiden Name Beulah Mae Reed
15. Birthplace Cambria, Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 27 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 29 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18 1946 at 8:27 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1946 to 11-18 1946 and that I last saw him alive on 11-18 1946

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G15965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Iola Reamy

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 8, 1876

8. AGE: Years: 70 | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business:

FATHER: 12. Name: Wilbur L. Settin
13. Birthplace: Del York Co. Pa.

MOTHER: 14. Maiden Name: Martha J. York
15. Birthplace: Del Kent Co.

16 (a) Informant: Mrs Martha A. Smith
(b) Address: 825 Northern Pky

17 (a) Burial, cremation, or removal: Druid Ridge (b) Date thereof: 11/30/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md

18 (a) Funeral director: Wilbur Cook Jr
(b) Address: 1219 E Pont St

19 (a) [illegible] Huntington Williams Md
(Date received by registrar) Registrar

NOV. 29 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1946, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 1939 to Nov 27 1946, and that I last saw h[illegible] alive on Nov 27 1946

Immediate cause of death: Coronary occlusion — Duration: 1 week
Due to: Arteriosclerotic heart disease — 10 yrs
Due to: Generalized arteriosclerosis. — 10 yrs
Other Conditions: Diabetes
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operations:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature: A. S. Chaffantreau M.D.
Address: 6710 York Rd Date signed: Nov 28

G15966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 430

Registered No. G15966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6220 Brook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6220 Brook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Carrie Morris Forwood

3 (b) **If veteran, name war** NO

3 (c) **Social Security Account No.** NONE

4. **Sex** Female

5. **Color or race** White

6 (a) **Single, married, widowed, or divorced** Widowed

6 (b) **Name of husband or wife** Fred F. Forwood

6 (c) **If alive, give age** years

7. **Birth date of deceased** (mo., day, yr.) Oct 18th 1873

8. AGE: Years	Months	Days	If less than one day
73	1	9	hr. min.

9. **Birthplace** Balto Md (Town, county, and state)

10. **Usual Occupation** Housewife

11. **Industry or business** At Home

FATHER
12. **Name** James Gourley
13. **Birthplace** Ireland

MOTHER
14. **Maiden Name** Mary F. Weaver
15. **Birthplace** Balto. Md.

16 (a) **Informant** Mrs. Belle Welch
(b) **Address** 6220 Brook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Forest Hill
Location Harford Co. Md.

18 (a) **Funeral director** William Cook Inc.
(b) **Address** 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10a NOV 29 1946

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Nov. 27, 1946, at 5-30 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11, 1946, to Nov. 27 1946, and that I last saw h alive on Nov. 26 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to Generalized arteriosclerosis	5
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** Harold A. Grott M. D.
Address 8100 Harford Rd Date signed 11/27/46

Contingent Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15367 — Registered No. G15367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

File No. 106037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bal 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 McKean Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Murdock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30th 1874

8. AGE: Years	Months	Days	If less than one day
71	11	27	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Murdock
13. Birthplace ?

MOTHER
14. Maiden Name Louise Moore
15. Birthplace W.Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Hollins & Gilmor Sts

19 (a) (b)
Name of clergyman Minister

NOV 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th 1946 at 8.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12th 1946, to Nov. 27 1946. and that I last saw h alive on 19

Immediate cause of death Cardiac failure — Duration

Due to Generalized arteriosclerosis

Due to General debility & Pneumonia

Other Conditions Carcinoma of mouth with metastases to cervical chain. Pulmonary abscess
(Include pregnancy within 3 months of death)

Date of operation 11/14/1946

Major findings of operation: Biopsy of mass of mouth

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Gibbs, M. D.
Address Balt. City Hospitals Date signed 11/29/46

G13988 — BALTIMORE CITY HEALTH DEPARTMENT — G13988

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 2
(e) Length of stay in Baltimore (yrs., mos., or days) L

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Maine Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca V. Kuhn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Joseph A. Kuhn Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1885

8. AGE: Years 61 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace York Co Pa (Town, county and state)

10. Usual Occupation Housewife

11. Industry or Business

FATHER 12. Name Helmut Coben

13. Birthplace Unknown

MOTHER 14. Maiden Name Thomas

15. Birthplace Unknown

16 (a) Informant Joseph A. Kuhn Sr.

(b) Address 1604 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1946 (month) (day) (year)

(c) Cemetery or crematory St. Joseph's Cem

Location Hagerstown Md

18 (a) Funeral director Hasley H. Zumwalt

(b) Address 1204 Edgewood Ave Huntington West Virginia

19 (a) (Date received by Registrar) (b) Registrar

NOV 29 1946

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1946, at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946 to Nov 28 1946 and that I last saw him alive on Nov 28 1946.

Immediate cause of death: Cardiovascular renal failure — Duration

Due to Malignancy of Urinary Tract or Genitalia Pelvis with Generalized Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 2, 1946

Major findings of operation: Metastatic Malignancy

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Reich MD

Address Redwood & Greene Sts Date signed 11/29/46

X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write up the causes of death clearly and legibly.

G15969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G15969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 Groveland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Groveland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Clarence Reamy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Auguste Reamy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 17 1863

8. AGE: Years	Months	Days	If less than one day
83		10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation P.O.Dept
11. Industry or business U.S.GoVt.

FATHER 12. Name William Andrew Reamy
13. Birthplace Virginia

MOTHER 14. Maiden Name Catherine Broaddus
15. Birthplace Unknown

16 (a) Informant Helen M.Reamy
(b) Address 4403 Groveland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Harry Thuscott
(b) Address 4204 Ridgewood Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1946, at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 to 28 1946 and that I last saw h alive on 19

Immediate cause of death: Cancer of the urethra — Duration: Sudden

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature: Howard D. Jarrell, M.D.
Address 3902 Groveland Date signed 11/28/46

VS-196 NOV 29 1946

For B.C.J. Jabinski, by Howard D. Jarrell, M.D.

G15970 BC# F63281 **BALTIMORE CITY HEALTH DEPARTMENT** G15970
CERTIFICATE OF DEATH 54a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 Aiken St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Aiken St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Frances Seiler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1942

8. AGE: Years 4 | Months 4 | Days 8. | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl H. Seiler
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Myrtle B. Beeson
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Myrtle Seiler
(b) Address 2124 Aiken St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Byfield
(b) Address 1600 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

NOV 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1946, at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946, to Nov. 27 1946 and that I last saw h CY alive on NOV. 27 1946.

Immediate cause of death: Brain tumor-Cystic glioma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H W Frantum M.D.
Address 1123 St Paul St Date signed 11-27-46

G15971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G15971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5613 Pimlico Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Towson Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Murdock Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenore VanSant Wagner

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1888

8. AGE: Years	Months	Days	If less than one day
57	11	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk Enoch Pratt Library
11. Industry or business

FATHER
12. Name Harry M. Wagner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Harriett VanSa nt
15. Birthplace Rahway, N. J.

16 (a) Informant Mr. H. Milton Wagner
(b) Address 622 W. Pratt St.

17 (a) Burial (b) Date thereof 11/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) (b) Registrar
(Date rec'd by registrar)

NOV 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946, to Nov. 27 1946, and that I last saw her alive on Nov. 27 1946

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	7
Due to	
Other Conditions Fracture left femur	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 53.0
(b) Date of occurrence Nov. 15 1946, at 5 M
(c) Where did injury occur? 505 Murdock Rd.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped and fell at home

23. Signature Margaret H. Nelson M. D.
Address 516 W. Pennsylvania Ave Date signed 11-29-46

For Dr. J. P. Davis, by Howard J. Weaver, M.D. X

G15972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. G15972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 W University Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. University Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabel L. Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1886

8. AGE: Years	Months	Days	If less than one day
60	3	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sect'y
11. Industry or business 1st. Nat'l Bank

FATHER
12. Name William Gibson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name ? Wolfe
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. J. O. Robinson
(b) Address 108 Overhall Rd. -10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ Greenmount Cem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. Md. 17

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1946, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Illuminating gas poison

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-27-46 7.45 a.m.
(b) Where did injury occur? 106 W. University Parkway
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation of gas from unfit gas stove burners

23. Signature Geo. L. Merrill M.D. Medical Examiner.
Date signed 11/27/46

G15073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G15073

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Bolton Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE JACKSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Harvey Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1886

8. AGE: Years 60 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John McCombs
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Ireland

16 (a) Informant Mr. James Harvey Jackson
(b) Address 1706 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 11.50 M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 11/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

615371 BALTIMORE CITY HEALTH DEPARTMENT 615371
CERTIFICATE OF DEATH 83a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution St. Agnes 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Fred. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted] Harry E. Parks

3 (b) If veteran, name war: None
3 (c) Social Security Account No.?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louella W. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1906

8. AGE: Years	Months	Days	If less than one day
40	3	18	hr. min.

9. Birthplace Va. · Middlesex Co. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Benjamin R. Park
13. Birthplace Va
MOTHER 14. Maiden Name Sarah Parker
15. Birthplace Va.

16 (a) Informant Mrs. Louella W. Parks, Wife
(b) Address 4504 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery Meadowridge Mem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) NOV 29 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27- 1946 at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to 11-27- 1946 and that I last saw h[illegible] alive on 11-27- 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 3½ hrs.
Due to Arterial Hypertension — 1½ yrs.
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Lloyd Johnson M. D.
Address Catonsville Md. Date signed 11/27/46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registration No. 15-3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1542 Moreland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 Moreland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSIE VIRGINIA BOYD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Russell M. Boyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1899

8. AGE: Years	Months	Days	If less than one day
47	2	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard T. Simmons
13. Birthplace Md.

MOTHER
14. Maiden Name Annie C. Kirwan
15. Birthplace Md.

16 (a) Informant Mr. Russell M. Boyd
(b) Address 1542 Moreland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 29 1946 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1946 to Nov. 27 1946 and that I last saw h[illegible] alive on Nov. 27 1946

Immediate cause of death Coronary Thrombosis — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 2401 W. North Ave. Date signed 11/27/46

C15976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C15976 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3600 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Hayward Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence L. Frazier

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 2 12- 05-0727

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Amelia Frazier (nee Walters)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1887

8. AGE: Years	Months	Days	If less than one day
59	8	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Repairman
11. Industry or business C. & P. Tel. Co.

FATHER
12. Name William Wallace Frazier
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Hart
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. C. E. Brough
(b) Address 3600 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Moreland park Cem.
Location Parkville, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/46 19 , at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 11-27 1946 ; and that I last saw alive on 11-27 1946.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel H Culver M. D.
Address 5 E 11 Pembroke 42 Date signed 11-30-46

V S 190

Samuel H Culver

C15077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

C15077 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Carlisle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Carlisle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Veisock Gregory

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Charles E. Gregory
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1864

8. AGE: Years 82 | Months 2 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Michael Veisock
13. Birthplace Unknown

MOTHER 14. Maiden Name Eva Barbara Pflugh
15. Birthplace Unknown

16 (a) Informant Mary E. Lewis
(b) Address 3206 Carlisle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 29 1946 (Date received by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1946, at 4 30/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1945 to Nov 28, 1946 and that I last saw h. Er alive on Nov. 28 1946.

Immediate cause of death Senility
Myocarditis — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M B Lewis M.D.
Address 2K W. Monument St Date signed 11/29/46

VS 150

X

G15978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G15978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 Powhatan Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Powhatan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mable E. Rice

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Alfred C. Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1871

8. AGE: Years	Months	Days	If less than one day
75	5	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard M. Cochrane
13. Birthplace Canada

MOTHER
14. Maiden Name Mary E. Wood
15 Birthplace Calvert Co. Md.

16 (a) Informant Mr. Alfred C. Rice
(b) Address 3507 Powhatan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) (Date rec'd by registrar) (b) Huntington Hillcrest, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 3:30A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec ? 1945 to Nov. 27 1946 and that I last saw he alive on Nov. 27 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 5 days
Due to Arteriosclerosis and Hypertension
Due to
Other Conditions Hydronephrosis (left)
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Sullivan M. D.
Address 11 E. Chase St Date signed Nov 28 46

V S 150

NOV 29 1946

G15979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 Keswick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Keswick Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lydia Ann Younger

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Francis A. Younger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5-1862

8. AGE: Years 84 | Months 2 | Days 21 | If less than one day hrs. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Sparwasser
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Samuel F. Younger
(b) Address 3619 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29-1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Filed by registrar NOV 30 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26- 1946, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15-Nov 1945 to 26-Nov 1946 and that I last saw h[illegible] alive on 26 Nov 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerotic Cardiovascular Disease	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Edmunds M. D.
Address 2746 The Alameda Date 27 Nov 1946

VS 150

C15980 — BALTIMORE CITY HEALTH DEPARTMENT — 1937 — C15980

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 E. 36th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 E. 36th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary Boone Ross

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: John Tasley Ross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1876

8. AGE: Years 70 | Months 9 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER — 12. Name Gideon R. Boone
13. Birthplace Maryland

MOTHER — 14. Maiden Name Sarah Ross
15. Birthplace Maryland

16 (a) Informant Mrs. Cornelia Ross Bright
(b) Address 1306 E. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30 1936 (month) (day) (year)
(c) Cemetery or crematory Mt. Moriah Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Rusque Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1936, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1936 to Nov. 27 1936, and that I last saw h alive on Nov. 26 1936.

Immediate cause of death	Duration
Cardiac Decomp.	1 mo.
Due to Arteriosclerotic CVD & Hypertension	7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J. Lennon M.D.
Address 3511 Falls Rd Date signed 11-27-36

X

G15981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. G15981

MARGIN—RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Seranto Rd.
(c) ~~Hospital or~~ institution: Colonial Nursing Home 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Garrett ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Metta Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.
yo	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Emil Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Invalid
11. Industry or business

FATHER 12. Name (Unknown) Martins
13. Birthplace Germany

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Mildred Grill
(b) Address 2526 Garrett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) Filed NOV 29 1946 (b) Huntington Williams, Registrar
VS 150

For Edgar R. Davis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27th 1946, at 6.25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 27 1946 and that I last saw him alive on Nov 25 1946.

Immediate cause of death	Duration
(a) Bronchopneumonia	1 week
Due to Fracture of Hip.	
Due to Senility	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 9-1
(b) Date of occurrence Nov. 2, 1946 at 7 M
(c) Where did injury occur? 2526 Garrett ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Fell while getting out of auto.
23. Signature Howard L. Wendeln, M.D.
Address 776 Park Night Date signed Nov 29 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15082 — BALTIMORE CITY HEALTH DEPARTMENT — G15082

CERTIFICATE OF DEATH 1936

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3462 Seneca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAY M. MADAIRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Albert C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1 - 1876

8. AGE: Years	Months	Days	If less than one day
70	8	26	hr. min.

9. Birthplace Balto Co - Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Jacob Wilhelm
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Ruth Ingham
15. Birthplace Balto Co.

16 (a) Informant Mr Emerson Madairy
(b) Address 3462 Seneca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Baltimore

18 (a) Funeral director Leonard J. Keck
(b) Address 5305 Harford Rd.

19 (a) NOV 29 1946 (Date received by registrar) Attestation from Wills Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/46 19 at 9:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Ford M.D.
Medical Examiner
Date signed 11/28/46

C15383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

C15383 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 D
(e) Length of stay in Baltimore (yrs., mos., or days) 88

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Loudon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Melinda J Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Late Henry Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1858

8. AGE: Years 88 Months 3 Days 10 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Young
13. Birthplace Md.

MOTHER 14. Maiden Name Caroline Strickland
15. Birthplace Md.

16 (a) Informant Mrs. Ethel H. DeHoff
(b) Address 414 N. Loudon Park

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 29 '46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 30 of Fireleigh Ry

18 (a) Funeral director Harry H Wright
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 29 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1946, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1946, to 11/27 1946 and that I last saw h e alive on 11/27 1946.

Immediate cause of death: Respiratory failure
Due to: Senile debility
Due to: Fracture, scapula, left
Other Conditions: Contusion, back

Duration
about 30 days

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/27/46 at 6:30 PM
(c) Where did injury occur? 414-N. Loudon Ave (City or town) Baltimore (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell & crumpled on floor

23. Signature John E Mettee, M.D.
Address Maryland Gen'l Hosp Date signed 11/29/46

Geo. B. Merrill MD X

C15981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

C15984 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City. Maryland
(b) Street address 4609 Bayonne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 4609 Bayonne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward H. Plumer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-02-5357

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna L. Plumer
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 10/4/91

8. AGE: Years	Months	Days	If less than one day
55	1	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Bank clerk
11. Industry or business Federal Reserve

FATHER
12. Name Joseph Plumer
13. Birthplace Balto Co Md.

MOTHER
14. Maiden Name Theresa Raab
15. Birthplace Balto Co Md.

16 (a) Informant Mrs. E. H. Plumer
(b) Address 4609 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lasselle Funeral Home
(b) Address 740 Belair Rd.

19 (a) NOV 29 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th 1946, at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7, 1940 to Nov 27, 1946 and that I last saw him alive on 11-26-1946

Immediate cause of death Coronary Occlusion (sudden termination) — Duration 6 yrs (or est) 6 yrs (or once)

Due to Arteriosclerosis + Hypertension

Due to Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Williamson M. D.
Address 5713 Bel Air Rd Date signed 11-27-46
Balto, Md.

VS 180

G15985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

Registered No. G15985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 Garden Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Matyseki

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3.10.97

8. AGE: Years	Months	Days	If less than one day
49	8	18	hr. min.

9. Birthplace Bohemia (Town, county, and State)

10. Usual Occupation Doll Collector

11. Industry or business State Hospital born.

FATHER
12. Name Anton Matyseki Sr
13. Birthplace Bohemia

MOTHER
14. Maiden Name Johanna Prokop
15. Birthplace Bohemia

16 (a) Informant Mrs. Ed. Stecher
(b) Address 4510 Garden Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Mark Crackston
(b) Address 700 N. Eden St

19 (a) (Date rec'd by registrar) (b) Clinton Williams, Registrar

NOV 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/46 19 , at 2:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/28 19 46 to 11/27 19 46
and that I last saw h[illegible] alive on 11/30 19 46

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Uraemia	
Due to Chronic Nephritis	
Other Conditions — Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen J. Timmerlin
Address W. Jos. Street Date signed 11/29/46

X

G15986 BC# G 63324 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G15986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto. Catonsville
(c) City or town Baltimore 28 Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Newburg Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Seaman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28 1946

8. AGE: Years	Months	Days	If less than one day
			14 hr. 1 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ralph Seaman
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Brown
15. Birthplace Maryland

16 (a) Informant Mother
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave Balto

18 (a) Funeral director Easton Home
(b) Address 608 Frederick Ave Catons.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

JUV 29 1948

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1946, at 5:27 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1946 to Nov. 28 1946 and that I last saw him alive on Nov. 28 1946

Immediate cause of death: Prematurity Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams, M.D.
Address Mercy Hospital Date signed 11-28-46

G15987 BCH G63475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

X G15987 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Roper Ave.
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Chesshill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Breningel – Leslie Ann
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 26, 1946
8. AGE: Years | Months | Days 2 | If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nicholas Breningel
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anita Seppi
15. Birthplace Balto. Md.

16 (a) Informant Asst Balto Gen. Hosp
(b) Address Eager Ave & Dukeland St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location
18 (a) Funeral director John R. Denny
(b) Address 1242 Reed Ter., Catons
19 (a) NOV 29 1946 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1946 to 11-28 1946 and that I last saw h[illegible] alive on 19

Immediate cause of death — Duration
Atelectasis
Due to
Due to
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Thrapton M. D.
Address E. J. T. W. Balto Gen Hosp Date signed 11-28-46

VS 150

Huntington Williams, M.D.

G15088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G15088 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Waldorf Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Waldorf Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph Bloom

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-8684 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1886

8. AGE: Years	Months	Days	If less than one day
60	4	23	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Joseph Bloom
13. Birthplace Russia

MOTHER
14. Maiden Name Bryna ?
15. Birthplace Russia

16 (a) Informant Rose Bloom
(b) Address 2827 Waldorf Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 29 1946 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1946 at 12,45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1946 to Nov 29 1946 and that I last saw h alive on Nov 29 1946

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Levin
Address 4818 Reisterstown Rd Date signed Nov 29/46 M. D.

VS 150

G15089 G15089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Whitelock St
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grafton E. Thompson

3 (b) If veteran, name war: None

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1902

8. AGE: Years 44 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Tavern Owner

11. Industry or business

FATHER
12. Name William Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Nancy Tolbert
15. Birthplace md

16 (a) Informant Irene Thompson
(b) Address 1504 W Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date sig'd by Registrar) (b) Registrar

NOV 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1946, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Nov 25 1946 and that I last saw deceased alive on Nov 25 1946

Immediate cause of death

Carcinoma of Head

Due to Forth Progress — Duration: 2 yrs 5 Mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thos. Woodridge
Address Elkridge Date signed 11-27-46

G15990 × G15990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170C

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME STANLEY B. HATFIELD

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary E. Hatfield

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 7 1924

8. AGE — Years: 22 | Months: 10 | Days: 24 | If less than one day: ..... hr. ..... min.

9. Birthplace Woodbine Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Mach Man

11. Industry or business B&O Railroad

FATHER — 12. Name William F. Hatfield

FATHER — 13. Birthplace Md.

MOTHER — 14. Maiden Name Mary B. Allen

MOTHER — 15. Birthplace Md.

16 (a) Informant Wm. F. Hatfield

(b) Address Woodbine, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 / 46 (month) (day) (year)

(c) Cemetery or crematory Morgan Chapel

Location Woodbine Md.

18 (a) Funeral director C. M. Wath

(b) Address Westminster, Md. R.D.

19 (a) ..... (Date received by Registrar) (b) ..... Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1946, at 2.48 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Intracranial hemorrhage
Contusion of brain

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-29-46 at approx. 1.30 a.m.
(b) Where did injury occur? Rt. #40-Cooksville, St. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Passenger-auto struck tree

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-29-46

X

G15391 — BALTIMORE CITY HEALTH DEPARTMENT — G15391 Registered No.

CERTIFICATE OF DEATH 1937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 N. Lombard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1729 N Lombard (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Durham

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife Peter Durham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1871

8. AGE: Years	Months	Days	If less than one day
65	-	-	hr. min.

9. Birthplace Not Known (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John Burnsheph
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs J Shreckhardt
(b) Address 1729 N. Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Cedarcrest
Location Md Memorial Park Co Joppa Rd

18 (a) Funeral director J. Foley Kane
(b) Address 1818 Light St.

NOV 29 1946 Huntington Williams, M.D.
(Date filed in Registrar's office)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1946, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1946 to Nov 27 1946 and that I last saw h alive on Nov 27 1946

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Elliott Seagmiller M. D.
Address 1729 N Lombard Date signed 11/23/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15993 BCH G 33928 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 109 B Registered No. X G15993

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk. (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Mallard Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-45

8. AGE: Years 1 | Months 13 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Smith
13. Birthplace Md

MOTHER
14. Maiden Name Louise Parks
15. Birthplace S. C.

16 (a) Informant Reynolds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory Asbury Mem'l Pk.
Location Balto County Md

18 (a) Funeral director Chas. H. Cooper
(b) Address 512 Cathedral St.

19 (a) (Date rec'd by registrar) (b) Washington Williams, Registrar

NOV 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946, at 5.57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1946 to Nov. 25 1946, and that I last saw him alive on Nov. 25 1946.

Immediate cause of death: ACUTE CARDIAC FAILURE — Duration: 1 DAY

Due to: PNEUMONIA — 11 DAYS

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H Harding
Address Johns Hopkins Hosp. Date signed 11 | 25 | 46 (M. D.)

X

G15093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G15093 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 711 W. Lombard st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred Craglow

3 (b) If veteran, name war: World War I + II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
54 (52)	6	12	hr. min.

9. Birthplace Forest Ohio (Town, county, and state)

10. Usual Occupation U.S. Dept Agriculture

11. Industry or business

FATHER 12. Name Hiredolphus Craglow
13. Birthplace Ohio

MOTHER 14. Maiden Name Alice Nealy
15. Birthplace Ohio

16 (a) Informant Kenneth C Craglow Sr.
(b) Address #9 Poplar Ave Takoma Park

17 (a) Removal (b) Date thereof May 29, 1946
(Burial, cremation, or removal) (month) (day) (year)
Burial (c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director J. Agnew Walters
(b) Address 257 Carroll St. Wash, D.C.

MAY 29 1946 (b) Burington for Williams
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28-1946 at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Coronary Occlusion - Myocardial Degeneration

Due to

Other Conditions Hypertension.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G15994 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 Ensor Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Ensor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Mary Breen

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-4246

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John A. Breen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1892

8. AGE: Years	Months	Days	If less than one day
54	0	7	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles McCabe
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Brady
15. Birthplace Ireland

16 (a) Informant Genevieve Breen
(b) Address 1719 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) (Date rec'd by registrar) (b)

VS 15a NOV 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1946, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1946, to 11/29 1946, and that I last saw her alive on 11/27 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 11/29/46
Due to: Hypertension — one year
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blumm M. D.
Address 1206 E. Preston St. Date signed 11/29/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G15995 — Registered No. G15995

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Wyman Park Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Wyman Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM FRANKLIN NORRIS, SR.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 716-12-3750

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude B. Norris

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) March 16, 1880

8. AGE: Years: 66 | Months: 8 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Pennsylvania R. R. Co.

FATHER
12. Name: Joseph Franklin Norris
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Eliza Ann McCauley
15. Birthplace: Maryland

16 (a) Informant: Mrs. Gertrude B. Norris
(b) Address: 301 Wyman Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) (Date rec'd by registrar) NOV 29 1946 (b) Signature for William Reimer

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1946 at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an Aug & Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to: Arteriosclerotic Cardio-Vascular disease

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner.
Date signed Nov 28, 1946

G15996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √164c

Registered No. G15996

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2764- Alameda Boulevard 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Thomas

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna M. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1862

8. AGE: Years	Months	Days	If less than one day
84	9	23	hr. min.

9. Birthplace Martinsburg W Va.
(Town, county and state)
10. Usual Occupation Boiler Engineer
11. Industry or business

FATHER
12. Name Harry Thomas
13. Birthplace Martinsburg W. Va

MOTHER
14. Maiden Name Don't know
15. Birthplace " "

16 (a) Informant Clarence M. Thomas
(b) Address 409 Clay St Houston Texas

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof Nov 30, 1946 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto City

18 (a) Funeral director A. Howard Feenan Sons
(b) Address 14 W. Fayette St Baltimore Md

19 (a) [illegible] (Date received by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1946 at 9.10 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun shot of brain, fracture of skull, hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/25/46 at 2.30 P. M.
(b) Where did injury occur? 2764 Alameda Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Firearm - revolver.

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 11-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1130

Registered No. G15397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (24)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 R. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley B. Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-7838

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife (Nee Hallman) Bertha E. Taylor
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March 23 - 1874

8. AGE: Years	Months	Days	If less than one day
72	8	4	hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)
10. Usual Occupation Bookkeeping Clerk for
11. Industry or business Nat'l Enameling & Stamping Co.

FATHER
12. Name Jno M. Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Barbara Rogers
15. Birthplace Virginia

16 (a) Informant Mrs. W.B. Taylor (Wife)
(b) Address 3511 R. Balto. St. Balto 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md

18 (a) Funeral director G. Howard Evans
(b) Address 1405 St Charles St., Balto 39 Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1946 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1946 to 11-27 1946, and that I last saw h[illegible] alive on 11-27 1946.

Duration

Immediate cause of death: Respiratory failure
Due to: Subacute glomerular nephritis
Due to:
Other Conditions: Anoxaemia, Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert T. May M. D.
Address Calvert + Saratoga Sts. Date signed 11-27-46

VS. 100

Huntington Williams, Md

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN. G15098 98025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G15098 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11- 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widower

6 (b) Name of husband or wife Mary (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6th 1876

8. AGE: Years	Months	Days	If less than one day
70	10	20	hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Jackson
13. Birthplace Boston Mass.

MOTHER
14. Maiden Name Polly ?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29. 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Bianty ave

19 (a) (Date rec'd by registrar) (b)

NOV 29 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26th 1946, at 8.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22nd 1945 to Nov. 26 1946 and that I last saw h alive on 19

Immediate cause of death Respiratory failure

Due to Bronchopneumonia

Due to

Other Conditions H A S C Valve

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Dougle Weldon M.D.
Address B. C. H. Date signed 11/26/46

X

G15999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

G15999

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 N. Spring Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Ivery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Weldon, N. C. (Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Robert Ivory.
(b) Address Weldon, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantly Ave

19 (a) (Date rec'd by registrar) (b) Lexington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1946 at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 3. ✓

(a) Date of injury 11/23/46 at 7:20 P.M.
(b) Where did injury occur? 1118 E. Preston St.
(c) Did injury occur at home, on farm, industrial place, in public place? Laughlin's house While at work? No.
(d) Means of injury Firearms — revolver
(e) Signature Thomas J. Mullen M.D. Medical Examiner.
Date signed 11/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR JINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. (7,600)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Normandy Isle Miami Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Evergleades Concourse (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Sands

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elsie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-29-1888

8. AGE: Years	Months	Days	If less than one day
58	2		hr. min.

9. Birthplace Ill (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER 12. Name John Sands
13. Birthplace N.Y.

MOTHER 14. Maiden Name Rosa A Adams
15. Birthplace Ill

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Chgo Ill
Location Chgo Ill.

18 (a) Funeral director John A Sands & Co
(b) Address 1400 Sutton Place

19 (a) (Date rec'd by registrar) (b) Huntington West Va

NOV 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 13 1946 to Nov. 29 1946, and that I last saw him alive on Nov. 29 1946.

Immediate cause of death	Duration
Undetermined	
Due to Gastro-ileostomy (surgical) ← Sup	
Due to Marked coronary	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Arm Knight, Jr.
Address John Hopkins Hosp Date signed 11/29/46

PHYSIC
Underlie
cause to
death sho
charged
tically.

X

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 21 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH [illegible] AND ENDING WITH 46000 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL